MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE-BASED RELATIVE VALUE SCALE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE-BASED RELATIVE VALUE SCALE

TUESDAY JUNE 25, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:08 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, JUNE 19, 1991

PRESS RELEASE #16
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE-BASED RELATIVE VALUE SCALE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Medicare payment to physicians under the resource-based relative value scale (RB RVS). The hearing will be held on Tuesday, June 25, 1991, beginning at 9:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark stated, "The RB RVS represents the first-ever comprehensive reform of physician payments. Its implementation will eliminate the irrational distortions in fees that have developed under the current system.

Some physician groups have raised concerns regarding the conversion factor proposed in the draft regulation published by the Administration. This hearing will provide an opportunity to explore this and other issues within this proposed rule."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Since its enactment in 1965, Medicare payments to physicians have been based on the so-called "reasonable charge" reimbursement system.

Section 6102 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) provided for a comprehensive reform of payments to physicians under Part B of the Medicare program. This provision established a fee schedule for physician services based on the resource-based relative value scale (RB RVS), effective January 1, 1992. This legislation also established the Medicare Volume Performance Standard system for updating fees, and created limits on the amounts that physicians can bill beneficiaries in excess of the amount allowed by Medicare.

The RB RVS fee schedule will be set by the Health Care Financing Administration (HCFA), and will be based on a relative value scale that assigns relative value units (RVUs) to each service. The RVUs will reflect the variations in fees resulting from differences in the resources required in providing each service. The fee paid for each service will be calculated by multiplying the number of RVUs assigned to a service by a conversion factor.

OBRA 1989 also provided for variations in fees between geographic areas, including bonus payments for services provided in health manpower shortage areas. Variations in fees between different specialties of physicians were prohibited.

The RB RVS will be phased in between 1992 and 1995. In the first year, services with historical fees above the RB RVS amounts will be paid the greater of the RB RVS amount, or the historical fee minus 15 percent of the RB RVS fee. For services with fees below the RB RVS fee, payments will be the lesser of the RB RVS amount, or the historical fee plus 15 percent of the RB RVS amount.

(MORE)

In 1993 through 1995, payments for physician services will be based on a blend of the RB RVS fees and the 1992 payment amounts. After 1995, payments will be based solely on the RB RVS.

On June 6, 1991, HCFA published a notice of proposed rule-making (NPRM) for the implementation of the RB RVS on January 1, 1992.

In the NPRM, HCFA has proposed to reduce the conversion factor by 16 percent to account for the estimated changes in expenditures in 1992 that are due to the transition and to the projected increase in volume of physician services in response to changes in fees under the RB RVS.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, July 1, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The Subcommittee on Health will commence a hearing that I wish never had to happen. We are going to watch a group of angels dance on the head of a pin this morning, and you are going to hear testimony that should never have taken place. Fault is a useless concept. The bill is ambiguous in many of its places. There is a lot of blame to pass around, and the major share of it can fall with this subcommittee, its Chair, and the staff.

I would like to call to the witness table at this point Dr. Eisenberg and Dr. Nelson from the AMA. I want to get three groups up here and get this thing ironed out to some extent if we can.

Just to review the bidding, and I have read the testimony until much earlier this morning than I wish I had, it is amazing how many people can determine what the intent of this committee was, particularly when the Chair remembers with about as much ability as his memory will permit things much differently than the two most opposing groups remember.

This bill was designed, in spite of what the AMA may suggest to you, to save money. This committee is not in this business of helping doctors work out their intramural squabbles as to who gets paid what. If anybody thinks that we went through the exercise we did for any other but budget savings, they ought to think again. I think that the testimony will bear us out.

Admittedly, the idea was that we were to contain the rate of increase and the Hsiao study and the relative resource-based relative value scale was an accident of timing which happened to fit into a program.

The intent of this committee was quite clear. We started out to save money in the aggregate. The AMA in a most disingenuous and deceptive advertising campaign suggested that this would cause rationing and incurred the wrath of this subcommittee on both sides of the aisle.

But they persisted until they confused the earnings target to the point that they are in the problem they are in today. They brought it on themselves. The Senate aided them, and we, in our lack of caution, did not review the legislation as it came out, very carefully. It is confusing.

But at this point in time, several things are apparent. First of all, when people talk about budget neutrality relative to the fee schedule, that never existed, it never came up in testimony. It is a figment of the administration's imagination.

That you could take fees and adjust them within the relative value scale is obvious. The relative value scale wasn't finished when this legislation was reported out, and of course it was intended that fees would change within the scale. And of course it was intended that the bill would be budget neutral, but that did not mean, and it was never suggested for 1 minute, that the index would be changed.

It was presumed that at some point in the future, once the relative value scale might have been agreed to for all of the procedures, that it would be easy to adjust the relative value scale based on volume retrospectively, and that was indeed hammered out over and over in the conference. Then, after observing the activities of the physicians, we could at that point later in the game change the index.

I don't think that there was ever any question about the intent of this committee. It may not be drafted that way clearly, and arguably that is our fault.

The other side of the coin, for the AMA to argue that this is a 16 percent cut, is disingenuous. It is not a 16 percent cut.

The best testimony and the one voice of clarity, as so often happens, comes from PhysPRC, who points out the ambiguity, who points out the fact that it is not clear to whether budget neutrality had anything to do with the transition fees. PhysPRC points out that the administration has opted to take the worst-case scenario at every point to their advantage. And that is the problem.

The AMA's testimony does them no credit. It is disingenuous, and it suggests that there will never be any volume changes. Of course there will be volume changes.

HCFA's assumption on volume changes is somewhat ludicrous; it ascribes volume changes and thereby penalizes physicians who have no control at all over their volume.

Can a person tell me how an anesthesiologist controls his or her own volume? I would be surprised that they have not increased or doubled their volume by now. Certainly, their incentives to increase volume exist just because the price of Porsches went up.

So we have here some groups that ought to have come together and are attempting to create some unnecessary advantages because of the inability of this committee to write clear legislation. For that, I apologize.

What I am suggesting is after having looked through the testimony of the three witnesses at the table—unfortunately, I haven't had a chance to review the testimony of the other witnesses—it becomes very clear that neither the administration nor the AMA makes a sound case.

I would hope that before we have to go very much further, and I mean in a period of a week or two, people will get together and figure out, in consultation with the subcommittee and Senate committee, what the intent was, so we get back on track.

This committee, if the AMA will recall, and they seldom make it public, was the one who saved their butts from the fee freezes when it was imposed by a Republican administration for longer than they promised.

I intend to bargain on behalf of the taxpayers. I intend to see that the rate of increase of physicians' fees does not increase at 11 or 12 or 15 percent, but more normally it would seem to me closer to the rate of inflation.

I don't intend to listen to access as a problem. Any physician who thinks they want to practice substandard medicine ought to deal with the local district attorney. That is not the issue.

The issue here is that we had a system, and it should work. If the witnesses will stop taking what I think is unnecessary advantage of reasonable confusion, come back to the idea that we are going to cut the rate of increase, we will get it done.

To that extent, I want you to cautiously review your testimony as you present it this morning.

[The statement follows:]

OPENING STATEMENT OF HON. PETE STARK

Good morning.

In 1989, Congress passed landmark legislation providing for the first-ever comprehensive reform of Medicare payments to physicians.

This reform had three parts:

1. Realignment of fees according to a resource-based relative value scale, or RB RVS;

2. A system of Medicare Volume Performance Standards that establishes limits on the rate of growth in expenditures; and

3. Limits on the amounts that physicians can bill over and above the fees that Medicare allows.

The second and third of these three parts have already been implemented.

On June 5th, HCFA published a proposed rule, or NPRM, to implement the final part, the RB RVS. This proposed rule is the subject of today's hearing.

The proposed rule is very complex and raises many issues. First and foremost is the issue of the appropriate level for the total payments.

I have heard, and I understand, the concerns of the physician groups who feel the Administration may have used the opportunity of this rule to achieve budgetary savings by setting the conversion factor at a reduced level.

The long range effect of this rule if implemented as proposed, and if the Administration's assumptions are correct, would be gradually to reduce fees to physicians so that expenditures would be $3 billion lower in 1996 than they otherwise would be. Aggregate payments would be as much as $7 billion lower over the five year transition period.

Physicians are understandably troubled by this proposed reduction in Medicare payments.

On the other hand, projections show that, despite the proposed reduction in fees, expenditures will continue to grow at a rate of 10.5 percent per year. Total Medicare payments to physicians are estimated to increase from $27 billion in 1991 to $45 billion in 1996.

The physician payment reform legislation also included a system of Medicare Volume Performance Standards.

This system, which was agreed by everyone as part of the overall package, anticipated growth in payments at an annual rate of between 8 and 9 percent per year over the course of the RB RVS transition.

Thus, even under the draft regulations, expenditures are estimated to grow faster than the rate agreed to by Congress.

Physician payment reform will succeed if and only if all of its objectives are met:

1. Physicians must be paid fairly;

2. The rate of growth in expenditures must be held to acceptable levels; and

3. Beneficiaries must be protected against extra-billing.

Over the next several months, I will be working to guarantee that these objectives are met. I want to assure that physicians are treated fairly and that the reform is faithfully implemented as enacted.

I hope that the Administration will join with me in resolving the many important questions that will be raised here today.

This morning our hearing is starting at an earlier hour than customary to accommodate an unusually large number of witnesses. Even so, there are many additional associations who wanted to testify. I hope that each of the groups who were not able to testify in person will make the effort to submit written testimony and give the Subcommittee the benefit of their views.

I would like to thank all of our witnesses for their contributions today. These issues are extremely complex, and the testimony will assist the Subcommittee in exploring these questions.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman. I was trying to follow your statement on your prepared text. I had a hard time catching up with it some place here. [Laughter.]

Chairman STARK. It tends to diverge. It was written before 3 o'clock this morning.

Mr. MCGRATH. I understand. Was that when you finished reading the testimony?

Let me say that there is a lot of controversy over these particular regs. This room is not big enough for all the people who want to be heard on this, and hopefully this afternoon we will be able to adjust our room so that everybody can be accommodated.

I am interested in hearing the testimony of our witnesses today. Hopefully, we can clear up some of this ambiguity you talk about, and hopefully, we can come to a peaceful resolution of what is turning into a pretty ugly situation.

With that, I just want to thank the chairman and our witnesses for coming today. This is an opportunity to hopefully find a way through this mire that has been presented to us, and hopefully come to, as I say, a peaceful resolution of a pretty ugly situation.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. I simply want to say the chairman has been very kind to let me sit in on these hearings and occasionally ask a question. I really came today to hear how this really works, having spent some time in the past using purloined copies of the California relative scale to set fees for various health and welfare labor trusts.

I have some hands-on knowledge of this whole business, and I am curious to see how this is all working out. I would hope that there will be a time for question a little bit later.

Thank you.

Chairman STARK. Thank you. With the indulgence of the committee, it will be the Chair's intention if we can, and particularly with the first panel, to interrupt the witnesses from time to time during their testimony, because my memory is bad. If I try and remember the question until the end of the testimony, I will forget it, and usually they are so good.

So with that in mind, I want to thank the witnesses for accommodating the Chair for becoming a panel at the 11th hour. Dr. Wilensky, please to proceed with an outline or explanation or detailed summary of the administration testimony.

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. WILENSKY. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the proposed physician fee schedule, one of the three pieces of the physician payment reform enacted in OBRA 1989.

The development of the fee schedule proposed rule has involved a great deal of work by HCFA and a large amount of input from outside groups. Let me emphasize that the proposed rule was published to invite public comment. We encourage groups to submit comments by the August 5 deadline.

The development of a national fee schedule is a large undertaking. It is much more complicated than hospital payment reform. Physicians are paid for some 7,000 different services. There are some 500,000 physicians, and we pay almost a half a billion physician bills.

We believe that the proposed fee schedule successfully accomplishes the goal of physician payment reform. The fee schedule cor-

rects historical imbalances in Medicare physician fees. It sets the right relative prices for services.

The fee schedule will help the very physicians it was designed to help. It redistributes Medicare fees to primary care services in low-priced geographic areas and away from surgical and diagnostic procedures in high-priced areas.

Fees for medical visits in 1992 will increase over 8 percent before the fee update, compared to the 1991 fees under the old system.

In previous testimony, I indicated that the default physician update is estimated to be 2.2 percent, although Congress can set the update at any level. With this update, fees for medical visits would average 10.7 percent more than 1991 levels.

In addition, a 10-percent add-on to the fee schedule is provided for physicians who provide services in all rural or urban health manpower shortage areas.

While the fee schedule restructures fees, Medicare outlays for physician services will continue to grow rapidly. During the fee schedule phase-in, Medicare physician spending will grow 63 percent, from $27 to $45 billion, a hefty 10.3 percent per year.

Let me turn to the issues of the fee schedule transition and behavioral adjustment.

Chairman STARK. Do you have the year-by-year breakdown? In your testimony, I have 1992 numbers and 1996 numbers, but not the in-betweens. Is that available? Do you have it with you?

Ms. WILENSKY. Certainly.

Chairman STARK. OK. I will just get back to it later. Thank you.

Ms. WILENSKY. You have probably heard that the transition results in 1996 Medicare outlays that are 6 percent, or $3 billion lower than what would have happened under the old system. It is true, as best we can estimate.

This occurs because of the transition rules and the budget neutrality requirement. The statute requires that the fee schedule be budget neutral in 199——

Chairman STARK. Where in the statute does it require that the fee schedule be budget neutral, and not the bill?

Ms. WILENSKY. I don't have the statute in front of me. I will provide——

Chairman STARK. The AMA quotes language that clouds that——

Ms. WILENSKY. I understand.

Chairman STARK. Go ahead.

Ms. WILENSKY. OK. Under budget neutrality, we spent no more and no less than we would have spent under the old system. The statute also requires a 5-year phase in.

For 1992, historical payment amounts will increase or decrease no more than 15 percent of the fee schedule. If the historical amounts are within 15 percent of the fee schedule, they are paid at the fee schedule.

The nature of the transition is asymmetric, because the low fees come up faster than the high fees come down. Physicians come up or down 15 percent from where they are going, not where they are coming from.

Let me give you an example. A service for which the historical amount is $100 and the fee schedule is $50 would be reduced by 15 percent, or $7.50 in 1992. On the other hand, a service for which

the historical amount is $50 and the fee schedule is $100 would also be increased by 15 percent of $100, that is $15 in 1992.

The transition eases the reduction for physicians with high fees and helps physicians with low fees get to the fee schedule more quickly.

When the transition rules are applied, expenditures are 2 percent greater than budget neutrality would allow. To restore budget neutrality, fees must be adjusted in a way that simultaneously is consistent with the transition rules.

We do not believe we can reduce all fees by 2 percent, because that would be inconsistent with the transition rules.

Chairman STARK. Let me ask another question. Would it be inconsistent to take high-priced procedures and reduce them? Is there anything in the law that would prevent that? If you have the same dollar yield?

Ms. WILENSKY. My understanding, and again I will be glad to provide you either a written clarification or any other information based on the statutory——

Chairman STARK. We did it in 1990 after 1989. Nobody raised the issue then, didn't we? We cut high-priced——

Ms. WILENSKY. That we cut high-priced procedures? Yes, we cut high-priced procedures.

Chairman STARK. And nobody said that violated the 1989 law. I don't recall anybody raising that issue. If the opthamologists had thought about it, they might have, but they didn't. Go ahead.

Ms. WILENSKY. The way to restore budget neutrality and meet the transition rules is to adjust the conversion factor. Because the fee schedule conversion factor only applies to one-third of the fees in 1992, the 2 percent multiplies into a 6-percent conversion factor reduction.

It is not our intention for the transition rule to reduce Medicare spending in this way, but we believe the proposed rule is based on the correct interpretation of the law. We have looked for other interpretations of the statute. In our opinion, we found none that did not violate either the statutory transition rules or the requirement for budget neutrality in 1992.

We would welcome, however, suggestions of alternative approaches that allow us to fulfill both statutory requirements.

Chairman STARK. Did you all talk to any of the Members of the House or Senate who wrote the bill in searching for this interpretation of the law?

Ms. WILENSKY. No. We relied on our general counsel.

Chairman STARK. Who I don't believe I have met.

Ms. WILENSKY. Well, we certainly would be glad to have that happen.

We believe that physicians and beneficiaries will respond to the fee changes, policy standardization, and changes in beneficiary out-of-pocket spending that occur under fee schedules.

We are not accusing physicians or beneficiaries of generating unnecessary services. Prior experience with payment changes has taught us to anticipate aggregate changes in volume and intensity of services.

The literature also indicates a behavioral response to fee changes. In its 1991 annual report to Congress, the Physician Pay-

ment Review Commission indicated that the results of several studies, including one by PhysPRC staff and another by CBO, suggests that the volume of services is affected by fee changes.

We observed a volume response to the Medicare fee freeze. The response was complicated by other factors, particularly the implementation of hospital PPS. However, when the data are adjusted for a sharp decline in PPS hospital admissions, increases in physician volume and intensity reached historically high levels in 1985 and 1986.

It would be imprudent to ignore all of this evidence and assume that no behavioral response will occur. Failure to account for behavioral changes would result in a conversion factor set too high, and consequently in greater part B spending than anticipated.

The volume performance standard is not an adequate mechanism to correct for a conversion factor set initially too high. When all is said and done——

Chairman STARK. Why is that?

Ms. WILENSKY. There are several reasons. The first is that in adjusting for the update, the base year figures under the default formula would have incorporated an inflated volume. That is, the fact that there would be a higher than appropriate expenditure that had occurred in 1992 would be in the base to which a lower update would apply.

Chairman STARK. Would there be anything to prohibit us from changing that with legislation?

Ms. WILENSKY. There are several things that could be done, but at least——

Chairman STARK. Would there be anything to prohibit us from doing that with legislation?

Ms. WILENSKY. We believe there is still some impact that would result even if the update reduction, which is limited to 2, 2½, and 3 percent in the statute, were changed. You still have the problem that, at least under the current legislation, there is use of a 5-year moving average volume and intensity in calculating the MVPS. So at least several different pieces of legislation would need to be changed.

Chairman STARK. It could be done.

Ms. WILENSKY. If all of those were changed——

Chairman STARK. And the only problem is it would result in a budget savings, isn't that correct?

Ms. WILENSKY. I beg your pardon?

Chairman STARK. If we reduced the baseline by legislation, there would be some budget savings.

Ms. WILENSKY. Over——

Chairman STARK. In the scoring. But other than that, it could be done that way. Also, you are very clear in suggesting that budget neutrality was in the law, but you don't suggest anywhere in your testimony that the law requires you to make these behavioral adjustments. You are saying that the use of behavioral adjustments is the most appropriate way to do it.

Ms. WILENSKY. That is correct.

Chairman STARK. But there is nothing in the bill that requires you to do it.

Ms. WILENSKY. That is correct.

Chairman STARK. Is that correct?
Ms. WILENSKY. For any change in behavior?
Chairman STARK. Right.
Ms. WILENSKY. That is correct.
Chairman STARK. OK.
Ms. WILENSKY. When all is said and done, we estimate that there will be a 3-percent increase in volume and intensity in 1992. Therefore, a 3-percent reduction in all fees is necessary to restore budget neutrality. Again, since the fee schedule affects only some of the services in 1992, a 3-percent increase in volume translates into a 10-percent conversion factor reduction.

The statute does not require budget neutrality for the transition years 1993 through 1995, and we have not proposed any behavioral adjustment for those years. However, had a behavioral adjustment been made for each of those years, the 1996 conversion factor would have been reduced by the same 10-percent.

Finally, I should note that the behavioral adjustment is included in legislative savings estimate, and thus increases the volume performance standard.

We should keep in perspective that projected increases in Medicare physician spending will top 10 percent per year, or 63 percent over the 5-year transition. Attention has focused on the 6-percent reduction in Medicare expenditures in 1996 due to the transition. However, this 6-percent reduction is relative to what spending would have been under the old system. It is not a drop in the absolute level of physician spending. It slows the rate of growth between 1991 and 1996 from 11.7 to 10.3 percent.

Medicare physician spending will increase from $27 to almost $45 billion between 1991 and 1996. Without the effect of the transition, Medicare spending would have increased to almost $48 billion.

The fact is that growth in physician spending continues to outpace growth in the overall national economy. Although the magnitude of increase under the fee schedule may not meet physicians' expectations, the growth in overall Medicare physician expenditures will continue to put substantial pressure on the Federal budget.

Let us remember that the fee schedule still preserves all of the perverse incentives inherent in fee-for-service medicine. Although the volume performance standard is intended to moderate increases in physician expenditures growth, it provides weak incentives for individual physicians to hold down the volume of services provided.

More direct incentives for physicians to control the volume and intensity of services delivered are needed. It is why I am so interested into bringing more beneficiaries into coordinated care plans. I believe it is the best way to moderate the growth in Medicare spending, while leaving the practice of medicine in the hands of physicians.

I look forward to working with you and physician groups as we move toward the completion of the fee schedule in October and a successful implementation in January.

I would be glad to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:
In 1989, Congress enacted major legislation to reform the Medicare payment system for physicians. Physician payment reform includes three key elements. First, the law sets a goal for the rate of Medicare physician expenditure growth, called the Medicare volume performance standard (MVPS). The difference between the MVPS and the actual rate of increase in expenditures is linked to the physician fee update two years later.

Second, a resource-based fee schedule replaces Medicare's customary, prevailing, and reasonable charge system. Finally, payment reform provides financial protection for Medicare beneficiaries by establishing limits on balance billing by nonparticipating physicians.

We recently sent Congress our second annual recommendation on the MVPS. The 1992 fee schedule update will mark the first year that physician payment increases will be adjusted to reflect actual expenditures relative to the MVPS. The physician fee schedule will begin to phase-in on January 1, 1992 and becomes fully effective in 1996. The new balance billing limits began on January 1, 1991 and will be fully in place by 1993.

I am pleased to be here today to discuss the proposed physician fee schedule. We recently published the proposed fee schedule regulation in the June 5th Federal Register. We strongly encourage all interested parties to submit comments on the proposed rule as soon as possible before the August 5th deadline. We have plenty of work ahead of us to develop the final regulation for October, send notices to inform physicians of program changes and fee schedule rates in November, and implementation of the fee schedule for 1992.

Reforming the physician payment system is a massive undertaking and is the most significant change to Part B of Medicare since the program's inception in 1965. Physician payment reform is, in many respects, much more complicated than the hospital prospective payment system (PPS). PPS put in place a bundled payment for hospital services, while the fee schedule largely maintains a fee-for-service system for physician services. Instead of 475 diagnosis-related groups and 6,000 hospitals, we are implementing a new payment system of 7,000 codes for 500,000 physicians. We handle more than 450 million Part B bills annually compared to 11 million hospital bills.

The relative values for physician services in the proposed rule cover more than 4,000 procedures and account for 85 percent of Medicare physician spending. Relative values for the balance of the procedures are still being developed and will be presented in the final rule.

The proposed physician fee schedule accomplishes its intended goal of setting the right relative prices for physician services. The proposed fee schedule corrects historical payment imbalances, especially in terms of the distribution of Medicare fees across types of services and geographic areas.

However, I would like to emphasize that, even with the MVPS, the fee schedule cannot and does not control the volume of services being delivered. We predict annual increases in Medicare physician expenditures of more than 10 percent over the next five years. Total increases over the five year period will be almost 63 percent. Physician expenditures are estimated to grow from $27 billion in 1991 to nearly $45 billion in 1996. The largest factor underlying this growth is the continuing increase in the volume and intensity of services. Other factors include inflation, the growth in Medicare enrollment, and the aging of the population.

PHYSICIAN FEE SCHEDULE AND BALANCE BILLING LIMITS

The statute specifies the framework of the fee schedule and gives the Secretary limited flexibility. The formula for computing

payment amounts, the transition rules, and the application of the geographic adjustment factor are all spelled out in the law. The new charge limits for nonparticipating physicians are also prescribed by statute.

A number of key policies and technical issues, however, were left to the Secretary to develop more fully. These issues are addressed in detail in the proposed regulation and include defining the global surgical package, developing new visit codes and specifying geographic adjustments.

Probably the most complicated aspect of the proposed fee schedule is its impact on physician fees and future Medicare outlays, particularly the effects of the transition rules and behavioral adjustment. Both issues are discussed later in my statement.

DEVELOPMENT OF THE PROPOSED FEE SCHEDULE

Fee schedule payment levels for physician services are computed using three factors: a relative value for the service; the geographic adjustment factor for the fee schedule area; and a dollar conversion factor.

Development of Relative Values

As required by statute, we have established relative values for physician work, physician practice expenses, and malpractice insurance. Work relative values are based on the relative resources, such as time and intensity of effort, required to provide each service. Practice expense and malpractice relative values are based on historical practice costs and an allowed charge amount for each service.

Physician Work Relative Values: The physician work relative values that form the basis of the fee schedule were developed by a research team at the Harvard University School of Public Health. On September 4, 1990, we published the Model Fee Schedule, which was based on Phase I of the Harvard research team's study. Phase I produced work relative values for approximately 1400 physician services in 18 physician specialties. These relative values represented almost 70 percent of Medicare Part B charges for physician services.

After publication of the Model Fee Schedule, we received Phase II of the Harvard study, which contained relative values for 15 additional specialties. Phase II also restudied eight Phase I specialties and made a number of refinements in the study methodology. These refinements explain some of the differences between the Model Fee Schedule and the proposed fee schedule. As required by law, the existing relative values for radiology and anesthesia services were integrated into the national fee schedule by rescaling the relative values for these services.

In Phase III, the Harvard research team is developing relative work values for the remaining physician services and refining some already established relative values. Some results of Phase III are included in the proposed regulation.

Practice Expense & Malpractice Relative Values: The statute prescribes that practice expense and malpractice relative values be computed by multiplying the weighted average historical practice cost shares for all specialties performing a service and a base allowed charge for the service. By law, the base allowed charge is the estimated 1991 national average Medicare allowed charge for each service. The historical cost shares were derived mainly from a 1989 American Medical Association (AMA) survey of office-based physicians' practice expense and malpractice costs.

Once the separate work, practice expense and malpractice relative values were established for each physician service in the proposed fee schedule, they were converted to a common scale and combined to produce a single relative value for each service.

Application of the Geographic Adjustment Factor
The fee schedule formula requires that the relative value for each physician service be adjusted to account for geographic cost differences, including differences in practice expense and malpractice costs. This was done using geographic adjustment factors that are based on geographic practice cost indices, or GPCIs, developed by the Urban Institute and the Center for Health Economics Research.

In summary, the GPCIs reflect the relative cost of practice expenses for wages and office rent compared to the national average; the relative cost of malpractice insurance compared to the national average; and the relative cost of physicians' work compared to the national average. The geographic adjustment factor for each procedure is equal to the weighted average of these GPCIs for each of the three relative value components. The statute specifies that only one-fourth of the geographic variation in physician work resource costs be taken into account.

Conversion Factor
The geographically-adjusted relative values for each physician service are then transformed into dollar payment amounts using a nationally uniform conversion factor. The statute requires that the 1992 conversion factor be budget neutral. In other words, the first year of physician payments under the fee schedule must equal the estimated 1991 payment under the existing customary, prevailing, and reasonable (CPR) system, plus the 1992 update amount. Budget neutrality means that we spend no more and no less than if the old CPR system had continued. I will discuss how a budget neutral conversion factor was calculated in greater detail later.

MAJOR POLICY ISSUES

Although the framework for the physician fee schedule was specified in statute, several policy areas and technical issues were left for our development. We have addressed these policy areas in detail in the proposed regulation and have requested specific public comment in a number of areas. Let me briefly highlight several of the major policy issues.

The statute requires that we establish standardized definitions and uniform codes so that all geographic areas and all physicians are treated in a like manner under the new payment system. Surgical services, medical visits and consultations constitute a large portion, approximately 75 percent, of Medicare physician spending. We have proposed the following standardized definitions for these services.

Definition of Global Surgery Package
Currently, surgeons generally bill a single, global fee for all services usually associated with a surgery, including pre-operative visits, the operation, intra-operative services, and follow-up care. The definition of global services for surgery, however, varies significantly among carriers, especially in terms of what constitutes pre-operative and post-operative care.

We are proposing a uniform, national global surgery policy that applies to all areas of the country and to all settings in order to eliminate this variation. The proposed global surgery package does not include the initial evaluation or consultation to determine the need for surgery, which would be paid separately.

All other pre-operative visits, from the time the decision to have the surgery is made, would be included. We are proposing a pre-operative period of up to 30 days. Services needed to stabilize a seriously ill patient before surgery will be paid separately. The operation itself and related intra-operative services would also be included in the global surgery package.

We have consulted with a number of surgeons and physician groups

to establish an appropriate payment policy for complications following surgery. A separate payment for complications would not be made for medical or surgical services required of the surgeon that do not require additional trips to the operating room. Return trips to the operating room, however, would be paid separately.

The global surgical fee would also include all post-operative visits by the primary surgeon within 90 days of the surgery. This does not include visits for problems unrelated to the surgery.

Development of New Visit Codes

In its research, the Harvard team found that the current visit codes, as defined in the AMA's CPT codes, are open to varying interpretation by physicians. In particular, the narrative descriptions of the codes do not clearly delineate differences among levels of service.

In the proposed regulation, we are advancing the adoption of new visit codes. For the past several years, the AMA and the Physician Payment Review Commission (PPRC) have been developing new visit codes that will improve coding consistency among physicians. Phase II results of the Harvard study supplemented that work.

The new CPT visit codes constitute a large change in how physicians code for services. In conjunction with the AMA, we pilot tested the new visit codes to determine their reliability. Preliminary results suggest that there is an improved consistency in coding by different physicians.

Implementation of a new visit coding system requires an assessment of the distribution of visits under the new codes. Therefore, a "crosswalk" between the old and new codes was necessary. The crosswalk we used is consistent with how physicians coded services in the pilot study and is also based on the comparisons of content descriptors of the new and old codes.

A 1990 OBRA provision restricts Medicare from reimbursing physicians separately for electrocardiogram (EKG) interpretations that are performed as part of a physician visit after January 1, 1992. We increased the physician work relative values for most office and hospital visit codes to compensate physicians for routine EKG interpretations. This adds approximately 1 to 3 percent to office and hospital visit fees.

Geographic Locality Changes

The law defines fee schedule geographic areas as the existing Medicare payment localities. While we believe we can change existing payment localities, it is not administratively feasible to make extensive locality changes at this time due to the enormous amount of change that will occur with implementation of the physician fee schedule. Therefore, we are proposing to retain current geographic locality designations, with two exceptions.

We are proposing single statewide fee schedule areas in 1992 for Nebraska and Oklahoma because they have demonstrated extensive support from both urban and rural physicians for such a change. Administratively, we are able to aggregate substate localities to a statewide locality, but we cannot move from substate locality system to another. We will consider changing geographic areas in other states where such support from both urban and rural physicians is also demonstrated.

We are reviewing options for reconfiguring the locality structure in the future. The PPRC and the Urban Institute have studied alternatives to the current locality structure.

In addition, providers furnishing services in all rural and urban areas health manpower shortage areas will receive a 10 percent Medicare bonus payment. The bonus payment was increased by statute from 5 to 10 percent beginning January 1, 1991, to encourage providers to remain in these shortage areas. These bonus payments are an add-on to the fee schedule payment amounts.

Treatment of Anesthesia Time

The statute also requires that we integrate the existing anesthesia relative values into the physician fee schedule. We currently use relative values developed by the American Society of Anesthesiologists. Under the current relative value guide for anesthesia services, payment is calculated using a base unit for specific procedures and an actual time unit, multiplied by a reasonable charge conversion factor.

The inclusion of actual time in computing payments is unique to anesthesia services. In a proposed rule in 1989 and in the Model Fee Schedule in 1990, we announced our intention to eliminate the separate time unit for anesthesia payments. We are now proposing, with the implementation of the fee schedule, to replace actual time with the average time for anesthesia services concurrent with the fee schedule implementation in 1992.

The fee schedule involves an averaging concept. In other words, we will make average payments for a procedure regardless of the time or difficulty of performing the service in a particular case. For example, we will pay one surgical fee for a procedure whether the case is unusually simple or unusually complicated.

Eliminating actual time would make the anesthesia payment methodology consistent with the methodology for all other physician services. If actual time were not eliminated, a different conversion factor for anesthesia services might be necessary, thereby separating anesthesiologists from the overall fee schedule.

Finally, we believe it is appropriate to eliminate actual time because the definition of when anesthesia time begins and ends is not consistently used by physicians. While general suggestions have been made to improve the definition of time, no specifics have been proposed.

A recent General Accounting Office study demonstrated that anesthesia time varies greatly for the same service. The GAO recommended that we eliminate the direct link between time and payment for anesthesia services.

Payment for Drugs

Medicare pays about $200 million annually for drugs furnished in physicians' offices that are not self-administrable. These include drugs furnished by injection or by infusion, such as chemotherapy and vitamin B-12 injections. Carriers currently use a variety of methods to pay for these drugs. We are proposing to establish a uniform drug payment policy for carriers.

A recent Office of the Inspector General study found that wholesale guides substantially overstate the true cost of drugs, and that pharmacies receive discounts averaging 16 percent of published wholesale prices. We believe that physicians also have the opportunity to achieve these discounts. Therefore, concurrent with the fee schedule implementation, we are proposing to pay physicians 85 percent of the average national wholesale price of the drug.

Drugs are not included under the fee schedule and therefore, they are outside the budget neutral requirement of the 1992 fee schedule. The estimated budgetary savings of our drug proposal

are $10 million in 1992 and $40 million in 1996.

CALCULATING A BUDGET NEUTRAL CONVERSION FACTOR

The final step in developing the proposed fee schedule was calculating the conversion factor. The conversion factor computation was complicated by the need to simultaneously fulfill two statutory requirements -- the transition rules and budget neutrality. We have set forth our best interpretation of the law, which is consistent with both requirements, without violating either. We have calculated a conversion factor of $26.873, a figure which applies before the 1992 fee update.

Accounting for Transition Rules

The transition rules require that the fee schedule be phased-in from 1992 through 1995. Physician services with a historical payment amount between 85 and 115 percent of the fee schedule will be paid at the fee schedule.

If the historical amount is below 85 percent of the fee schedule, the 1992 payment equals the historical amount plus 15 percent of the fee schedule. For physician services with historical amounts more than 115 percent of the fee schedule, the payment for 1992 is the historical amount minus 15 percent of the fee schedule. Payments in 1993 through 1995 continue to transition to the fee schedule using blended rates until the fee schedule is fully implemented for all services in 1996.

This type of transition to the fee schedule is asymmetric because services with low fees increase faster than services with high fees decrease. As a result, the transition rules have a net cost of 2 percent in 1992. To restore budget neutrality, fees must be adjusted in a way that simultaneously is consistent with the statutory transition rules.

We do not believe that we can reduce all fees by 2 percent because that would be inconsistent with the transition rules. The way to restore budget neutrality and meet the transition rules is to adjust the conversion factor. Because the fee schedule conversion factor only applies to some of the fees in 1992, the 2 percent figure "multiplies" into a 6 percent conversion factor reduction. Thus, the simultaneous fulfillment of both statutory requirements results in a 6 percent reduction in the conversion factor.

The 6 percent conversion factor adjustment does not achieve any savings in 1992. However, when the fee schedule is fully implemented in 1996 Medicare spending will be 6 percent lower than would have occurred under the CPR payment system. This 6 percent represents the $3 billion "savings" figure that has been reported.

It was not our intention for the transition to reduce Medicare spending in this way, but we believe that the proposed rule is based on the correct interpretation of the law. Indeed, we looked for other interpretations of the statute and found none that did not violate either the statutory transition or the requirement for 1992 budget neutrality. We welcome suggestions of alternative approaches that allow us to fulfill both statutory requirements.

Volume and Intensity Changes

Implementation of the fee schedule involves massive changes in how Medicare pays for physician services. For several reasons, we believe that changes in the volume and intensity of services will occur. Lower out-of-pocket costs may cause beneficiaries to seek additional services.

Likewise, reduced payments for some services and changes to standardized definitions of services for global surgical fees and

medical visits could also affect physician billing practices. Specifically, physicians may respond by billing under new definitions for services that they do not currently bill; billing for a higher level of service than they would have under the current system; or furnishing more services, particularly visits, concurrent care, consultations, and tests.

Whatever their source, we expect an aggregate volume and intensity response due to implementation of the fee schedule. Therefore, to fulfill the statutory budget neutrality requirement, adjustments must be made for anticipated behavioral changes.

Research supports this phenomenon. The PPRC, in its 1991 report to Congress, concluded that the results of several time-series studies suggest that the volume of services is affected by fee changes. In addition, Dr. William Hsiao, who developed the resource-based relative value scale, after an exhaustive review of empirical studies, reported in a recent paper that "physicians can affect the service mix and utilization rates to offset fee reductions."

In addition, our experience with the physician fee freeze in the mid-1980's showed that physicians do increase volume and intensity of services when fees are constrained. The response was complicated by other factors, particularly the implementation of the hospital PPS. However, when physician volume and intensity data are adjusted for a sharp decline in hospital admissions under PPS, increases in physician volume and intensity reached historically high levels in 1985 and 1986.

We believe that it would be imprudent to ignore all this evidence and assume that no behavioral response will occur. Failure to account for these behavioral changes would set the conversion factor too high and, consequently, result in Part B trust fund outlays larger than budgeted. This would increase the overall Federal budget deficit and pressure Congress to increase the Part B premium.

The MVPS is not an adequate mechanism to correct for a conversion factor initially set too high. By law, if the MVPS is exceeded, there is a limit on how much future updates can be reduced. Because there is a lag in making adjustments for excess payments using the update process, there would be a loss to the Federal treasury for two years.

Most importantly, the MVPS does not correct for an increase in the expenditure base that occurs for volume and intensity response that have not been anticipated. Future MVPSs would be applied to the inflated base. In addition, if we underestimate the aggregate volume and mix of services, not only would the base to which the MVPS is applied increase, but also the default MVPS and the Medicare physician spending baseline would increase.

Finally, I should note that the behavioral adjustment helps physicians when establishing the MVPS. The MVPS formula requires an adjustment for changes in law or regulation affecting the baseline. For example, when we determined the MVPS for 1990 and 1991, our adjustments for the OBRA savings provisions included a behavioral adjustment. This resulted in MVPSs higher than they would have been without behavioral adjustments.

We have assumed volume and intensity changes sufficient to offset 50 percent of a physician's net loss in Medicare revenues. This adjustment does not mean that we expect to see a 50 percent increase in physicians' services. We assume that individual physicians who experience a decline in Medicare revenues due to the fee schedule will recoup half of that loss by increasing volume and mix of services delivered. For example, if a physician's Medicare revenues decrease from $100,000 to $90,000

under the fee schedule, we estimate the behavioral effect to be 50 percent of $10,000, or a $5,000 increase in Medicare services billed. We have applied a behavioral adjustment only to physicians whose Medicare revenues decrease under the fee schedule. We have assumed that no adjustment for physicians who experience a net increase in Medicare revenues.

When all is said and done, we expect a 3 percent increase in volume in 1992. Thus, to restore budget neutrality, we would need to reduce fees for all services by about 3 percent in 1992. However, for the same reason the 2 percent transition adjustment multiplies to a 6 percent conversion factor reduction, a 3 percent increase in volume translates into a 10 percent conversion factor reduction.

The statute does not require budget neutrality for the transition years 1993 through 1995 and thus we have not proposed any behavioral adjustment for those years. Had a behavioral adjustment been made for each those years, the 1996 conversion factor would have been reduced by approximately the same 10 percent.

Interaction of the Transition Rules and Behavioral Adjustment
When the interaction of both the transition and behavioral offset are taken into account, fees will be reduced 16 percent by 1996 relative to estimated CPR fees in that year. I must emphasize, however, that when volume and intensity responses are taken into account, estimates of 1996 total Medicare physician outlays under the fee schedule would be reduced only 6 percent compared to outlays that would have occurred under the CPR system.

More importantly, this 6 percent reduction in overall payments is phased-in gradually over the transition to the fee schedule and effectively reduces the annual rate of increase of total Medicare physician spending from 11.7 percent to 10.3 percent per year. This means that we expect Medicare physician spending to increase from $27 billion in 1991 to almost $45 billion in 1996. Under the old CPR payment system, spending would have increased to $48 billion. The 10.3 percent average annual rate of increase in physician spending is substantially higher than the anticipated growth in the nation's economy.

IMPACT OF PHYSICIAN FEE SCHEDULE

As intended by Congress, the fee schedule sets the right relative values and redistributes fees among physicians. The attached tables show the impact of the fee schedule by physician specialty and by state. However, the impact on any individual physician would depend not only on specialty and locality, but also on historical charging patterns and the mix of services furnished.

In general, those specialties that account for more visits and fewer procedures are expected to experience larger total increases than procedure-oriented specialties. Physicians providing primary care services and located in historically low-charge areas will receive higher payments under the fee schedule. Payments for medical visits are expected to increase by as much as 8 percent in 1992, before the fee update. However, a primary care physician whose historical charges were unusually high or who performs more procedures than is typical could experience a small increase or even a decrease in Medicare payment.

Tables 1 and 2 show impacts by specialty. Tables 3 and 4 show impacts by state. In all four tables, the columns labeled "Payments Per Service" reflect fees while columns labeled "Payments" reflect total payments or outlays and take into account volume and intensity responses.

Tables 1 and 3 show that overall payments or outlays for all specialties and for all states is budget neutral in 1992 relative to estimated CPR outlays in that year. These tables also show

that all payments per service had to be reduced 3 percent in order to achieve budget neutrality due to anticipated increases in volume and intensity.

The effect of a fully phased-in fee schedule in 1996 relative to what would have occurred under the CPR system is shown in the third and fourth columns of tables 1 and 3. Payments per service or fees are reduced 16 percent relative to where CPR payments would have been in 1996 reflecting the effect of both the transition and the behavioral offset. The fourth column shows that overall Medicare payments or outlays will be reduced by 6 percent relative to where CPR payments would have been in 1996. The 6 percent reduction is due to the effect of the transition.

Between 1991 and 1996, the absolute level of Medicare outlays for physician services are projected to increase due to such factors as annual updates, enrollment growth and historical volume and intensity trends. These increases are shown in the fifth and sixth columns of tables 1 and 3. The cumulative increase in Medicare outlays is projected to be 63 percent or 10.3 percent annually over this period. This increase occurs even after the 6 percent effect of the transition.

Tables 2 and 4 display the changes in Medicare payments per service and overall payments by specialty and by state relative to the national average. The tables show that the fee schedule achieves the redistribution intended among specialties and states.

BENEFICIARY FINANCIAL PROTECTIONS

Physician payment reform also includes financial protections for Medicare beneficiaries in the form of new limits on the charges nonparticipating physicians are allowed to bill above Medicare payments. These new limits replace the maximum allowable actual charge (MAAC) system which has been in place since 1986.

The new charge limits prohibit nonparticipating physicians from charging more than 125 percent of the 1991 prevailing charge effective January 1, 1991 (except for primary care services where the 1991 limit is 140 percent). The balance billing limits are reduced for all services to 120 percent of the fee schedule amount beginning January 1, 1992. By 1993, the new charge limit is 115 percent of the fee schedule amount for nonparticipating physicians.

The implementation of the physician fee schedule and balance billing limits will effect a beneficiary's out-of-pocket expenses in terms of coinsurance and balance billing liability. The effect on any individual's out-of-pocket expenses depend on the geographic area and the mix of services received. Typically, the coinsurance for visits and consultations would increase, while coinsurance for surgical and diagnostic services would decrease. However, virtually all beneficiaries who receive services from nonparticipating physicians would benefit from the more stringent charge limits. On balance, beneficiary out-of-pocket expenses under the fee schedule are expected to decrease.

We will monitor the effects of physician payment reform on beneficiaries. We plan to monitor changes in utilization, access as well as changes in physician participation, assignment and beneficiary out-of-pocket expenses. Our new Common Working File will provide key claims data. The Current Beneficiary Survey, which is planned for implementation later this year, will provide us with relevant information regarding access and utilization of services.

CONCLUSION

I believe that the proposed fee schedule successfully accomplishes the goal of physician payment reform. The fee schedule corrects historical imbalances in Medicare physician

fees. The fee schedule sets the "right" relative prices for services. It redistributes Medicare fees to primary care services and low-priced geographic areas, and away from surgical and diagnostic procedures and high-priced areas.

Fees for medical visits in 1992 will increase over 8 percent, before the fee update, compared to 1991 fees under the old system. The fee schedule will help the very physicians it was designed to help -- the primary care physicians who deliver cognitive services and physicians who practice in historically low-charge areas.

In previous testimony, I indicated that the "default" update for physician services is estimated to be 2.2 percent, although Congress can set the update at any level. With a 2.2 percent update, Medicare fees for medical visits would average 10.7 percent higher than 1991 levels. In addition, a 10 percent bonus is provided for physicians who provide services in all rural or urban health manpower shortage areas. These bonus payments are an add-on to the fee schedule payment amounts.

The statute requires that the fee schedule be budget neutral in 1992 and specifies transition rules. The simultaneous fulfillment of both statutory requirements results in a 6 percent reduction relative to the CPR system in 1996. It was not our intention for the transition to reduce Medicare spending in this way, but we believe that the proposed rule is based on the correct interpretation of the law. To fulfill the statutory 1992 budget neutrality requirement, we believe that an aggregate adjustment to the conversion factor is needed to account for anticipated changes in the volume and intensity of services.

Medicare physician spending under the fee schedule is projected to increase 63 percent over the five-year transition. While attention has focused on the 6 percent reduction in Medicare expenditures by 1996 due to the transition, this reduction is relative to where outlays would have been under the old system.

It is not a drop in the absolute level of outlays. It is only a slowing of the rate of growth in Medicare physician spending between 1991 and 1996 from 11.7 percent to 10.3 percent.

Medicare physician spending will increase from $27 billion to almost $45 billion between 1991 and 1996. Without the effect of the transition, Medicare spending would have increased to almost $48 billion. This continued growth rate in Medicare physician expenditures is troubling. The simple fact is that physician expenditures continue to outpace growth in the national economy. What has been labeled a "cut" is really only a "Washington" cut, that is, a reduction in the rate of increase. Outside the Washington Beltway, a 10.3 percent annual increase is a significant amount.

Although physicians may be disappointed about the magnitude of increases under the fee schedule, the overall growth in Medicare physician expenditures will continue to put substantial pressure on the Federal budget. The fee schedule still preserves all the perverse incentives inherent in fee-for-service medicine. While the MVPS is intended to moderate increases in physician expenditure growth, it provides weak incentives for individual physicians to hold down the volume of services provided.

More direct incentives for physicians to control the volume and intensity of services delivered are needed. That is why I am so interested in bringing more beneficiaries into coordinated care plans. Coordinated care is the best way to moderate the growth in Medicare spending, while leaving the practice of medicine in the hands of physicians.

The development of the proposed rule has involved a great deal of

work by HCFA and a large amount of input from outside groups. We encourage groups to submit comments by the August 5th deadline. I look forward to working with you and physician groups as we move towards a final regulation in October and successful fee schedule implementation in January.

Thank you. I will be glad to answer any questions you may have.

Chairman STARK. I will come back to you. But in the meantime, I hope that while we listen to the other panelists, you could get for me for those years 1991 through 1996 the aggregate expenditures under your proposal and under present law.

One other question I want you to think about is, and we can come back to this, in the chart appended to your testimony, while you did say that there is nothing in the law that requires you to make it necessary, as you say on page 8, to adjust for anticipated estimated volume changes, you decided to do that.

I am not sure that there was anything in the legislative history or intent that said anything except that we plan to come back retrospectively after we observed the behavior and saw the total expenditures. Then we would adjust fees. That certainly was my clear recollection.

Even having said that, I will defer to Dr. McDermott. He could perhaps explain to me, if you presume that because psychiatrists will get cut 9 percent and then 5 percent in 1996, you are saying to stay even, they have to increase their volume 6 percent. So you expect a 3-percent cut in overall payments.

Now, when you practice by the hour, it seems to me unless you anticipate that the psychiatrist would cut a 55-minute session to 45 minutes, I don't see how they could increase their volume very much.

Anesthesiologists are going to have to find a lot of compliant surgeons to cut off some extra legs or remove some extra gall bladders. You are talking about a 17-percent increase in anesthesiology fees, and I am not sure that that is what you anticipate, where general surgery only goes up 11 percent. Now, unless they are going to knock them out twice, they aren't going to get an 11-percent increase in patients up to a 17-percent increase in volume.

Once you go down this road, I think you have to be prepared to defend it better than the information you have provided us.

By having said that, I would like next to hear the other side of this issue and hear from the representatives of the American Medical Association——

Mr. MCGRATH. Mr. Chairman.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. On that point, it seems that this is at the crux of the problem. Gail, you were recommending a 3 percent behavioral offset. The Physician Payment Review Commission recommends 1 percent. It seems, based on paragraph two of page 8, that this is what you are adjusting in order to become revenue neutral.

Ms. WILENSKY. Right, which is, in our understanding, required for 1992, which would not occur if you waited until 2 years later to use the volume performance standard.

You are correct, though, that we believe it would take a 3-percent adjustment. PPRC has said in its judgment 1 percent is——

Mr. MCGRATH. Are they playing under the same rules of revenue neutrality?

Ms. WILENSKY. I assume that they also believe that would give them budget neutrality, yes.

Mr. MCGRATH. I am going to be interested in hearing how these percentages of behavioral offset are going to be determined, in order to achieve the desired effect.

Everybody knows that that is the game. It is just a question of how we are going to play it. How you come up with that number and justify it in terms of the end result being revenue neutral is something I am going to be interested in hearing about.

Chairman STARK. Dr. Nelson from the AMA, if you would like to proceed. Why don't you outline for us the other side of the coin? We will get to PhysPRC third.

STATEMENT OF ALAN R. NELSON, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY JANET HORAN, SENIOR LEGISLATIVE COUNSEL

Dr. NELSON. Yes sir. I am Alan Nelson. I am a practicing physician in Salt Lake City in internal medicine. I am immediate past president of the AMA, and with me is Janet Horan of our staff. Dr. Jim Todd, our EVP, wanted me to particularly to express his regret that he couldn't be here. He is with our annual house of delegates.

Two years ago, the medical profession put special interests aside and worked with Members of Congress to enact the historic revision to the Medicare payment system for physician services. The goal we shared was to implement a more rational and predictable method of physician payment.

Physicians throughout America are angry at the proposed payment levels for Medicare services in the June 5, 1991, proposed rule to implement Medicare physician payment reform.

This is understandable, because the proposal reflects an unwarranted, devastating, and immediate 16 percent reduction in the schedule's initial conversion factor, contrary to the intent of Congress.

Chairman STARK. Could you give us an indication of what that lowers the overall rate of increase? Would you guess that it maybe lowers the aggregate payment from 11 to 10½ percent?

Dr. NELSON. Let me—16 percent is our calculation. It is other people's calculation.

Chairman STARK. No, I am talking about the aggregate payment. What do you think the rate of increase in aggregate payments to physicians will be after implementation? It went up the previous year maybe by 11 in round figures.

Dr. NELSON. I think it depends entirely in what specialty we are talking about.

Chairman STARK. No, I am talking the aggregate.

Dr. NELSON. Eight to ten.

Chairman STARK. Eight to ten?

Dr. NELSON. Yes.

Chairman STARK. That is a pretty broad range. I would submit to you that we think it is about 10½, down from 11 percent. That sounds a little less radical, than a 16½ percent cut doesn't it? If we are going to get to a compromise. The way you phrase things becomes very important, and I would urge the AMA that that is all you are going to get, that we try to keep these numbers in perspective for those who are somewhat less or more confused than the Chair. Go ahead.

Dr. NELSON. But even more important, physicians are worried. They and the AMA are worried that the proposed schedule of payments with the drastic cuts for many services is going to mean that some Medicare patients may not have access to the full range of services that they want and need.

Let me give an example. One of my colleagues in Utah, Randy Rogers, settled in a small community because he wanted to be a country doctor. He moved to a suburban community after 6 years because reimbursement levels were too low for him to stay in practice in a community which had a large percentage of Medicare and Medicaid patients.

In his new location, he took a practice management consultant's advice and restricts his practice to non-Medicare and non-Medicaid patients in order to keep his practice viable. I don't like that fact, but it is a fact.

And Mr. Chairman, when you say not to talk about access, I have to talk about access, because we have to talk about whether we want to create a Medicare program with programs equal to or worse than——

Chairman STARK. Doctor, are you aware of the number of physicians who now participate?

Dr. NELSON. I know that the participation rates are going up——

Chairman STARK. It is going up.

Dr. NELSON. I also know that——

Chairman STARK. So to Randy Rogers, I can say bye-bye Randy, enjoy your Porsche, we will find somebody to replace you who remembers the Hippocratic Oath and is willing to practice for a reasonable rate. An HMO could also move in there and do the job that Randy doesn't want. We will miss Randy, but if he wants to move to Park Avenue, this is a free country.

Dr. NELSON. People in his small town miss Randy.

Chairman STARK. I will bet. Particularly the Medicare beneficiaries.

Dr. NELSON. The assignment rates are going up, but I am worried that the number of physicians who are continuing to take new Medicare patients is going down, and that is a fact. I am worried that the Medicare program is going to have the problems that the Medicaid program has.

This proposed 16-percent reduction in the conversion factor results from a misinterpretation by HCFA of the mandate for budget neutrality contained in OBRA 1989 as well as from inappropriate and demeaning assumptions about anticipated physician behavior in response to physician payment reform.

Chairman STARK. Why is that demeaning? Is it any more demeaning to suggest that a physician wants to make money than a Congressman wants to make money? Do you think physicians don't like to enjoy a good life?

Dr. NELSON. It is demeaning to patients as well as to physicians——

Chairman STARK. No, no, but why is it demeaning to physicians? It seems to me, while I disagree with Dr. Wilensky's interpretation of what would happen, physician volume for the last 20 years has been going up.

Dr. NELSON. I can't agree with your assumption that a surgeon is going to do unnecessary surgery——

Chairman STARK. Nobody said that, Doctor. The word unnecessary comes entirely from your own imagination. It is likely that a surgeon might decide to shave a few strokes off their golf game and do a little surgery on Wednesday afternoons to increase their income.

That, in fact, increases their volume. Nobody is suggesting that that is unnecessary. And they might decide to buy an interest in an MRI. They can do many things that would increase overall volume.

It has been the experience of the part B program for the last 10 or 15 years that volume has gone up more than severity, more than age, more than population would indicate. Now, it isn't the chiropractors, and it isn't the Christian Science practitioners. It's the doctors. That is not demeaning. That is a fact.

The fact that she may have used those numbers to break faith with what the bill intended is another issue. I would suggest to you, however, that if you want to represent the doctors well, you will deal with finding out how we can get back to what the law intended and not worry about any imagined sleight to the reputation of the doctors. That was not intended by HCFA or anybody else. It is interpreting a fact of life.

Dr. NELSON. The studies that have been done and cited don't show that there is a behavioral offset. There are a whole host of reasons why increased volumes of services historically have been——

Chairman STARK. But they do go up, right?

Dr. NELSON. Certainly, many more mammograms are being done now than were before, appropriately so, as new technology——

Chairman STARK. No question. So is that demeaning? It is probably good medicine.

Dr. NELSON. No——

Chairman STARK. Not to have more mammograms?

Dr. NELSON. No. To the degree that it talks about the payment system driving the volume, we don't agree with it.

Chairman STARK. Look, you just said the reason the doctor moved was because he wasn't getting enough money, right? And Randy was going to get more money or more volume——

Dr. NELSON. He moved because he couldn't pay his overhead.

Chairman STARK. Well, all right, that is money. So I am just saying there is nothing wrong with earning money. Let us deal with what we are here to deal with this morning, and that is to get this very complicated procedure on track again. Go ahead. I am sorry for the interruption.

Dr. NELSON. Finally, HCFA has applied all of its budget cutting actions into the conversion factor, thereby tripling the effect on the conversion factor.

The AMA remains committed to physician payment reform. We simply want to make it work. Our house of delegates has been in an interesting exercise the last few days. A number of our members have questioned whether or not we should have supported the entire system.

We continue to be committed to it, we want to make it work, and we will continue to work with all of organized medicine——

Chairman STARK. Doctor, I can't let that one go by either. We passed it without your support. You opposed it until the end, and it wouldn't make any difference if the house of delegates decided to oppose it now. They couldn't turn it around. We passed it and got it signed. With the good help of the radiologists, the surgeons, and the family practitioners. The AMA did not make a whit of difference.

We appreciate your coming late to the table to support it, and I look forward to working with you to make it work, but you aren't going to undo it. So figure out how to make it work, and don't suggest that whatever the house of delegates does will make any difference.

Dr. NELSON. I think that the participation of the AMA in the Hsiao study and working with PPRC has been a very important role. Our record is clear in showing that we have been participants in this process.

Our approach includes the following elements: Clarification that OBRA 1989 neither requires nor allows HCFA to cut payments for Medicare services because the 1992 transition might not be budget neutral, and second, a congressional directive that HCFA use no behavioral offset, because it has no clear analytic or statutory basis.

In conclusion, Congress as much as anyone has a major stake in seeing a smooth transition to physician payment reform. Fair relative values linked to an absurd conversion factor do not produce fair payment levels. Access may then become a real concern.

A PPRC survey of Medicaid rates for a hysterectomy indicate that Medicare rates will be near or below the Medicaid rate in such cities as Boston, Chicago, Cincinnati, Milwaukee, New Britain, Oakland, Pittsburgh, and Seattle.

Furthermore, increases in rural areas will be substantially reduced, with 40 States suffering losses in Medicare payments in 1992, and 49 States suffering losses in the next 5 years.

Thank you for permitting us to testify.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

WAYS AND MEANS COMMITTEE
HEALTH SUBCOMMITTEE
U.S. HOUSE OF REPRESENTATIVES

RE: MEDICARE IMPLEMENTATION OF PHYSICIAN PAYMENT REFORM

presented by

ALAN R. NELSON, M.D.

June 25, 1991

The physicians of America are outraged at the proposed payment levels in the June 5, 1991 Notice of Proposed Rule Making (NPRM) on Medicare physician payment reform. The NPRM reflects a devastating and immediate 16% reduction in the schedule's initial conversion factor. Overall payments, not just payments per service, will be reduced by this 16% payment reduction. The medical profession appreciates the Committee's prompt action to hold this hearing to identify problems in the NPRM so that you can assist by making corrections that will keep physician payment reform on track.

Two years ago the medical profession put special interests aside and worked with Members of Congress to enact a historic revision of the Medicare payment system for physicians' services. The common goal was to implement a more rational and predictable method of physician payment. Legislative history makes it clear that Medicare physician payment reform was not to be used as a budget cutting device. In fact, Congress went to great lengths to emphasize that the transition to the new payment system should be implemented on a budget neutral basis. However, budget neutral implementation will not occur if the NPRM is allowed to become final as proposed.

The medical profession supported payment reform based on assurances from Congress and the Physician Payment Review Commission (PPRC) that it would be implemented in a fair and reasonable manner, and would not be used as a device to slash the budget. Contrary to Congress' intent and its commitment to physicians, and as HCFA's own analysis demonstrates, the proposed conversion factor does transform payment reform into a budget cutting tool. Physicians' confidence in and cooperation with payment reform and the Medicare program are in serious jeopardy. However, these cuts are not automatic or inevitable. They will only result from final policy decisions by HCFA. They can and must be reversed--either by HCFA or by the Congress.

According to the physician payment reform provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), payment amounts in each locality will be determined by an RBRVS, a geographic adjustment factor, and a monetary conversion factor, which converts the relative value units (RVUs) into dollars. Congress intended for payment reform to neither increase nor decrease overall Medicare payments to physicians. However, HCFA's own interpretation of the OBRA-89 legislation that is reflected in the NPRM produces a severe 16% reduction in the proposed conversion factor for the new payment schedule from an otherwise "budget neutral" level.

This drastic reduction is in turn reflected in the NPRM's simulations of the impact of payment reform on specialties and states. The simulations show projected payment increases for physicians in rural states and in primary care specialties to be substantially lower than previous forecasts. The simulations also show steeper payment cuts for urban areas and for surgical specialties.

In contrast, the Congressional intent of physician payment reform was to increase Medicare payments to physicians providing primary care and rural services for physicians such as those in family practice and internal medicine and to moderate losses. If these proposals are finalized in their present form, physicians can only conclude that the federal government has broken faith with the medical profession and its patients.

PROPOSED CONVERSION FACTOR REDUCTION

The proposed 16% reduction in the conversion factor results from a misinterpretation by HCFA of the mandate for budget neutrality contained in OBRA-89, as well as from inappropriate and demeaning assumptions about anticipated physician behavior in response to payment reform. OBRA-89 requires the agency to establish a conversion factor such that aggregate Medicare expenditures for physician services in 1992 will be the same as they would have been under a continuation of the current payment system. HCFA has interpreted this provision as requiring two reductions in the conversion factor: One to offset volume increases that it projects will occur as a behavioral response to payment reductions; and one to offset spending projected to result from the payment system's transition formula for 1992.

Volume Offset Assumption

The proposed volume offset is based on the view that payment changes alter the volume of services. This offset is based on HCFA's undocumented belief that expenditures will increase by $0.50 for every $1 payment reduction as physicians offset payment cuts. This assumption isnot justified and the AMA strongly opposes the use of any "behavioral" offset to reduce 1992 payments.

In the section of the NPRM that discusses global surgical packages, HCFA's statements about physician volume responses completely contradict its earlier statements in the conversion factor section. Explaining its appropriate decision to exclude all return trips to the operating room from the global package, HCFA states:

> We do not believe that paying for a surgeon's services during return trips to the operating room would result in abuse. We do not believe physicians would subject their patients to risk merely to secure additional payment. Nor do we believe that hospitals or peer review groups would permit this practice to continue if it did occur. (p. 25831, emphasis added.)

Because most of the services for which payments will be reduced under payment reform are surgical services, the agency is essentially advocating a contradictory view that physicians will subject their patients to unnecessary risk for an initial operation merely to secure additional payment, but they they will not subject their patients to the risk of reoperation merely for financial gain.

Furthermore, a recent symposium on this issue, jointly sponsored by the AMA and Project Hope, demonstrated that there is no firm analytic basis for HCFA's predictions about volume responses to payment changes, and that there is considerable uncertainty regarding the existence, magnitude, and direction of any potential changes in utilization as a response to changes in payment.

In the NPRM, HCFA attempts to justify its volume offset assumptions by citing the many simultaneous changes occurring under payment reform, such as payment increases and decreases, new visit codes, global surgical packages, and balance billing limits. HCFA goes on to argue that these changes will in turn lead to utilization changes, and that their net effect will be an increase in Medicare spending. On the contrary, the many simultaneous changes only add to the uncertainty surrounding volume and expenditure projections.

The mechanism established by Congress, the Medicare Volume Performance Standard (MVPS), was to respond to potential inappropriate increases in volume. HCFA attempts in the NPRM to refute this argument by stating that the MVPS is an inadequate tool for correcting such increases. The reasons given are that there are limits on the amount by which the payment update may be reduced if the MVPS is exceeded, there is a full two-year period between the volume increase and the reduction in the payment update, there is an inability to reverse increases in the expenditure baseline. Furthermore, the limit applies only if Congress does not act on the payment update. Congress still has the authority to supersede the limit if it deems volume increases are excessive.

Moreover, HCFA's volume offset assumption is demeaning to physicians and patients. Regardless of its statements about responses to coding changes and limiting charges, the basis for this proposed conversion factor reduction is HCFA's belief that physicians will purposely increase volume to offset payment reductions. In responding to the Congressional Budget Office (CBO) position that payment increases will also produce volume decreases, HCFA states that: "We have much less experience with observing behavioral responses to increases in fees" (p. 25823). In truth, the agency has no clear evidence of a behavioral response to payment reductions.

Transition Formula Correction

Because HCFA estimates the transition formula will lead to an increase in Medicare spending in 1992 as a result of payment increases occurring faster than payment decreases, a payment reduction to correct for the effects of the transition formula is proposed. HCFA does acknowledge that OBRA-89 does not reconcile the transition rules with the budget neutrality requirement.

We believe that the statute is, in fact, clear on this point. The statute requires that the budget neutral conversion factor is to be calculated "without regard" to the transition paragraphs and their potential budget consequences. This language is plain on its face and consistent with Congress' intent to accelerate increases in primary care and rural services and to prevent precipitous cuts in other services.

Tripling Effect

The third factor contributing to the severe proposed reduction in the conversion factor is HCFA's interpretation of the OBRA-89 budget neutrality provision as requiring that the behavioral offset reduction and the transition correction be addressed solely through the payment schedule conversion factor even though Medicare payments for most services in 1992 will be a blend of the new payment schedule and adjusted current payments. HCFA has estimated that because of the resulting tripling effects, a 16% reduction in the conversion factor is required to produce the 5% reduction in Medicare payments (a 3% volume offset plus a 2% transition formula correction) that it estimates is necessary to maintain budget neutrality in 1992. In addition, although there is no requirement for budget neutrality in the years subsequent to 1992, the 16% reduction will have a substantial down-the-road impact. By 1996, when the payment schedule is fully implemented, the cut will constitute enormous reductions in Medicare physician payments.

While there are numerous sections of the NPRM where HCFA attempts to assess Congressional intent and concludes that the statutory language must be in error or is sufficiently ambiguous to allow for various interpretations, no such analysis of Congress' wishes is reflected in this section. In fact, this massive cut is contrary to Congressional goals. In reforming Medicare's physician payment system, Congress clearly intended to increase patient access to primary care services and improve the availability to physicians' services in rural areas. In sharp contrast to this intent, HCFA's regulatory impact analysis demonstrates that its proposed 16% conversion factor reduction, if finalized, would nullify projected payment increases for primary care physicians and rural areas.

In addition, the proposed reduction would deepen payment cuts for surgical and other specialties. Proposed cuts of 20% for general surgeons, 35% for ophthalmologists, and 31% for thoracic surgeons, particularly following several years of "overvalued" procedure reductions, will bring some Medicare payments near to or below Medicaid levels, with serious consequences for elderly and disabled patients' access to care. For example, a PPRC survey of Medicaid rates for a hysterectomy indicate that Medicare rates will be near or below the Medicaid rate in such cities as Boston, Chicago, Cincinnati, Milwaukee, New Britain, Oakland, Pittsburgh and Seattle. Furthermore, increases in rural areas will be substantially reduced with 40 states suffering losses in Medicare payments in 1992 and 49 states suffering losses in the next five years.

AMA PROPOSED SOLUTION

The AMA, working with all of organized medicine, is embarking on a major effort to reverse these cuts. We will use legislative proposals, an unprecedented grassroots campaign, and regulatory comments.

It is the position of the AMA that the problems that are causing the radical reduction in the conversion factor can be dealt with administratively. In May, we provided HCFA Administrator Wilensky with an explanation of the problems and a proposed administrative solution. To date, we have not received an official response from HCFA, but the NPRM does not accept these suggestions.

We expect that many physicians, including some delegates at our House of Delegates meeting, will call for repeal of physician payment reform. These sentiments are certainly understandable. We want to assure you, however, that the AMA remains committed to physician payment reform. We simply want to make it work. Thus, we will focus our attention on correction of the policy decisions based on HCFA's statutory misinterpretations so that payment reform can go forward as intended.

Our legislative approach includes the following elements:

First, for the so-called transition asymmetry, we will seek further clarification that OBRA-89 neither requires nor allows HCFA to cut payments because the 1992 transition might not be budget neutral. The statute (42 U.S.C §1395 w-4(a)(2)(A-B)) states that services subject to transition limits will be paid "at an amount equal to the adjusted historical payment basis plus (or minus) 15 percent of the fee schedule amount otherwise established (without regard to this paragraph)." (Emphasis added.)

In the event that any transition-related adjustment is allowed, we will seek a correction for the current ambiguity so that any such adjustment is applied to the historical payment basis only, and not to the conversion factor. Success on this point eliminates about one third of the 16% cut.

Second, we will seek a Congressional directive that HCFA use no "behavioral offset." As stated earlier, there is no clear analytic basis for any such response. The fact that both the CBO and PPRC interpret the available evidence as indicating an offset of only 1% illustrates the range of legitimate opinion on this issue.

If any offset is to be allowed, however, we will seek a legislative instruction that HCFA utilize CBO assumptions that volume also will be reduced where payments increase. We also will ask that the statute be revised by requiring that any such offset be equally applied to the historical payment basis and the conversion factor. Eliminating or reducing this offset, and not placing all of the adjustment on the conversion factor, removes all, or at least most of the balance of the 16% cut.

Concerns have been raised that such a solution would be difficult to implement because of the Congressional "pay-as-you-go" budget rules, which would require that alternate budget savings be found to replace the savings projected to result from making all of the budget neutrality

adjustments through the conversion factor. Reiterating a point made in a June 10 hearing before the PPRC by James S. Todd, MD, AMA Executive Vice President: "We would prefer administrative and legislative approaches that will not trigger budget concerns. Nevertheless, we do not believe that physicians should be penalized under these 'pay-as-you-go' rules as a result of drafting ambiguity. We will not allow a faulty automatic pilot to drive payment reform onto the shoals of disaster."

CONCLUSION

Congress, as much as anyone, has a major stake in seeing a smooth transition to physician payment reform. For example, Congress based its call for balance billing limits on a belief that physicians should accept "fair" payments. These limits must now be reconsidered. "Fair" relative values linked to an absurd conversion factor do not produce fair payment levels. Access may become a real concern.

In conclusion, we would like to acknowledge that the NPRM involves much more than the conversion factor. We have many areas of concern and will submit our detailed preliminary comments for the record. (A copy of our final comments to the NPRM also will be forwarded to the Committee this August.) We are certainly gratified that HCFA worked so closely and effectively with the CPT editorial panel on visit code reform and has expressed clear interest in our proposal for an AMA/specialty society RVS update process.

Thank you for calling this hearing and inviting the AMA to testify. Your interest reflects our strong view that we have all invested too much time and effort on payment reform to see it destroyed.

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Mr. McGrath. Mr. Chairman, may I interject here for a moment?

Chairman Stark. Sure.

Mr. McGrath. Doctor, can I ask the question I put to Gail regarding the 3-percent behavorial modification as opposed to the 1 percent recommended by the Physician Payment Review Commission? Is it your contention that there is no percentage, is that what we are saying?

Dr. Nelson. We question the assumption. Research does not support the notion that volume is altered with payment change.

Mr. McGrath. So your contention is that although HCFA says it is 3 percent, and they say it is 1 percent, it is bogus because there is no——

Dr. Nelson. We don't know. Furthermore, as the chairman pointed out, there are ways to adjust, and fine tune and correct if it turns out that volume changes occur as a result of payment change.

Mr. McGrath. Do you accept that there would be a requirement for budget neutrality at the end of the procedure?

Dr. Nelson. The statute clearly presupposed budget neutrality in setting the conversion factor, and that is what we are talking about.

Mr. McGrath. In order to get to budget neutrality, both of these entities used a behavioral modification percentage. What would you use in order to achieve the budget neutrality that is required by the law?

Dr. Nelson. We don't think that it is necessary to budgetarily score a proposed rule at the front end. There is a mechanism to correct if it finds that a change is needed. We don't think that in setting the conversion factor one ought to assume the behavioral offset.

Mr. McGrath. We seem to have gotten down to the crux of the matter here. It seems everybody is bent out of shape over how you compute this conversion factor, I suspect.

Dr. Nelson. Yes.

Chairman Stark. I think now we are at the position I was at about 1 o'clock this morning. [Laughter.]

Then I started to read Dr. Eisenberg's testimony, and I put away the Maalox. I think now we will find a more reasoned approach to this dilemma, and that is the reason I, if the members will permit me further, changed somewhat the order of witnesses here.

I think now as between the two interpretations that the Physician Payment Review Commission has come up with, in the face of the ambiguity—which is our fault—they have come up with a suggested compromise that——

Mr. McGrath. I understand the compromise, but in order to get to the compromise, you have to accept a basic premise of how you achieve modification. They accept a behavioral change. AMA does not, based on the——

Chairman Stark. I think Dr. Nelson would agree that the law intended that if there were a behavioral change, we would come back retrospectively and knock the bejesus out of those rates.

We would lower the rates. That was very clearly intended. It is one of the reasons that the surgeons weren't going to let you bar-

gain for them, because they were afraid they could do a better job than you could.

There was no question that that would happen a year or 2 years subsequent to the first rates. We would say, if the volume went up, we will come back and lower the rates to pick up for that fact. That was clearly the intent. You might want to review that with staff, and I would like to ask our colleagues on the other side of the Capitol. To that point, I think the AMA is quite right.

To the fact that that may make it more difficult to fit this within the budget rules is also probably the case. That is where we are now. Perhaps Dr. Eisenberg might suggest a way out of that dilemma. We may have to legislate, but I don't see anything wrong with that.

At the beginning of this hearing, I suggested that we may have made a mistake by not writing clear legislation. We ought to be prepared to change that.

If the members would indulge me a little further, let us let Dr. Eisenberg go through his review of this, and I think maybe we will be pointed in the direction of a solution to the dilemma.

Welcome.

STATEMENT OF JOHN M. EISENBERG, M.D., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman. With that kind of an introduction, I should probably stop now. [Laughter.]

I hope that it wasn't our testimony that put you to sleep last night when you finished reading it.

I am pleased to be here on behalf of the Physician Payment Review Commission with Paul Ginsburg, the Executive Director of the Commission. I think the previous two speakers have pointed out the fact that the biggest issue is the conversion factor. There is another issue which we would like to point out which has to do with the scale of relative work. I will make some comments about that later.

In reading the testimony, I am sure that some of the members found much of this rather technical and arcane, and in some ways it is. But our feeling is that, these technicalities are critically important to ensuring that the legislation that was enacted is implemented as the Congress intended.

Our March report provides some detail on our interpretation of how that might take place. Let me first talk about the conversion factor. As we have heard, the Secretary's proposal would reduce fee levels by about 16 percent. There are at least four issues that we think should be addressed here.

The first one is the fact that the transition to the new fee schedule is asymmetrical. What that means is that because of the way the law was written, the high fees will go down more slowly than the low fees will go up. That is going to result in expenditures in the first year that exceed budget neutrality by 2 percent.

In order to correct for that, 2 percent has to be taken from the conversion factor. But only a third of services are being paid at the

fee schedule in the first year. So changes in the conversion factor affects only one-third of the services.

Therefore, in order to cut 2 percent overall, the conversion factor has to be reduced by three times 2 percent, or 6 percent. That is problem number one.

Our assessment is that something is going to have to be done about that, and we have a few solutions that we would like to suggest.

First, instead of applying the budget neutrality provision to the conversion factor, it could be applied to the historical payments, so that the historical payments would be reduced rather than the conversion factor. That would be relatively simple.

The second approach, which the Commission has considered and would like for you to consider, is the one that Congressman Stark has already mentioned, that is, a larger reduction in highly overvalued services. But that is a second approach that we believe would fit the intent of the legislation without having to reduce the conversion factor by 6 percent.

Now, there is another approach, which would be to totally reconsider the asymmetric nature of the transition, but that would be tough. However, it certainly could be on your platter.

Those are three approaches that you might take to this problem of the asymmetrical transition.

The second issue is the behavioral offset about which we have been talking. Our concern is that the behavioral offset is, in fact, based upon little information and few solid data, but we recognize the fact that someone is going to have to take the risk here. Will it be the physicians, or will it be the taxpayers?

And our sense was, it ought to be both. It ought not to be a situation where the entire risk for the behavioral offset is placed on the physician community, nor should it be placed entirely on the taxpayers.

Our solution, a 1-percent reduction in fees to correct for this potential behavioral phenomenon, is really a compromise. It is something which we felt would help to solve the problem, but not put the burden entirely on the physicians or entirely on the taxpayer.

We feel that the proposal that the administration has suggested, which is a 3-percent reduction rather than 1-percent, is too harsh. It is too large a response, and it is anticipating the worst-case scenario on the part of physician behavior.

In a sense, it is slapping physicians on the hand for misbehaving before they have had a chance to show how they will behave. We believe, therefore, that the behavioral offset needs to exist so that the risk can be shared, but HCFA's proposal is too high.

We also recognize, as you have suggested, that the volume performance standard was legislated specifically for this purpose. It was intended to deal with potential volume responses by physicians. It is there in the legislation, and it could be used retroactively to correct for any behavioral change that is greater than the anticipated change.

So we would prefer to see a behavioral offset that is lower. Our suggestion is 1 percent, and that the behavioral response be considered in light of the potential for the volume performance standard correction in the future.

Those are the two most important issues, the asymmetrical transition and the behavioral offset. There are some other issues that are important, though.

A new visit coding system is going to be used in the new payment system. We don't know how doctors are going to use these new visit codes. There is a term that we use here called cross-walk. How are doctors going to walk across from the old coding system to the new coding system for these visits?

And what we are concerned about here, again, is that the HCFA assumption is the most pessimistic. We have looked at log-diary surveys of physicians, which suggest that the HCFA-projected outlays may be much too high.

Now these are preliminary data, but they are the best data available. We believe, therefore, that the assumptions regarding the new visit codes would cause a reduction in payments to physicians under the new fee schedule that would be lower than we would anticipate.

Now, what can be done here? We could adjust future conversion factors based on actual billing by physicians. So again, we are suggesting that we not anticipate behavior so much as we observe it very carefully and see how physicians behave with these new visit codes. That is the third issue.

The fourth issue is whether or not physicians will submit all bills at the fee schedule level. Right now, a substantial minority of claims are not billed at the amount at which they could be billed under the current Medicare system.

HCFA's assumption has been that doctors will bring all of their bills up to the new fee schedule. Now, they may do that, but again, we don't know. We would prefer that the conversion factor in the future reflect the differences between the way doctors are projected to behave and what actually happens, rather than assuming that every doctor will bill for every service at the new Medicare fee schedule.

So, those are the four key issues on the conversion factor: asymmetry, the behavioral offset, the new visit codes, and how doctors are going to bill relative to the Medicare fee schedule.

The issue of the scale of relative work is an important one that we don't think has gotten enough attention. It involves some even more technical issues than those related to the conversion factor.

I won't go into those in detail unless you would like for me to, but the point is this: Many of the values for physician services do not accurately reflect the work involved in providing them.

We would like to work with our colleagues at HCFA to solve these problems. We believe that they can be solved without new research, and instead by looking at the best available data to further refine the scale of relative work.

We would rather not forge ahead by making a long-term and permanent decision about the scale of relative work before we have had a chance to do this refinement.

In fact, if it can't be done before the new fee schedule goes into place, although we believe it can, we would suggest that we give ourselves an opportunity after January of 1993 to go back and revisit these relative work values.

We think that these first two issues are the most important: the conversion factor and the scale of relative work. There are however, other issues like practice expenses. The assumption in the HCFA proposal is that doctors who are practicing outside of their offices, mostly in hospitals, have less overhead and therefore their payments should be reduced by 50 percent.

The PhysPRC is doing work now to try to assess the difference in practice expenses for services in-office versus out-of-office services. We believe that the gist of the HCFA proposal is correct; that is, that there probably are fewer expenses when you are practicing outside the office.

But we are not confident that the difference is this large. Furthermore, we believe that if we reduce payments for doctors for their out-of-office services, there ought to be a compensatory increase for the overhead that they have when practicing in their office. That is the practice expense issue.

There are also some issues regarding geographic payment areas. We have suggested, for simplicity's sake, frankly, that we reduce the number of payment areas to 94 from the current 237. It would reduce administrative expenses and result in greater simplicity in setting fees and fewer problems with doctors and patients crossing boundaries. It would just make things a lot simpler.

There are also some issues concerning anesthesia payment. We believe that anesthesiologists should continue to be paid for their actual time.

With electrocardiograms, we are concerned that the implementation of the legislation that eliminated payment for electrocardiograms done in conjunction with a visit, is not yet satisfactory. It spreads out the fee for the electrocardiogram over all visits, but we know that doctors, as we would expect, differ in the frequency of electrocardiograms they provide during their office visits.

We would like to see either a system of paying for the electrocardiograms according to the RBRVS or at least a system whereby we could pay in the short term for electrocardiograms according to the RBRVS until we can develop a better scheme for compensating physicians who are likely to be performing EKGs with their office visits.

We think that payment to new physicians is a problem. We believe physicians ought to be paid the same whether they are 1 year out of residency or 30 years out of residency——

Chairman STARK. If they are licensed.

Dr. EISENBERG. If they are licensed, of course. Therefore we believe that the fee schedule ought to pay all doctors the same, and that the new physician provision essentially ought to be eliminated.

I apologize for presenting so much detail. The real point is that we think that these problems are easily solvable, and that we can still be fiscally responsible to the taxpayer by changing some of the recommendations that HCFA has proposed.

We look forward to working together with the Congress and with HCFA to remedy these issues.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG, M.D., COMMISSIONER PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I appreciate the opportunity to testify this morning on behalf of the Physician Payment Review Commission concerning implementation of the Medicare Fee Schedule. The Commission reviewed the Health Care Financing Administration's (HCFA) Notice of Proposed Rulemaking (NPRM) at its June meeting. While it found much merit in the proposed rules, it also noted significant problems related to the conversion factor, the scale of relative work, and other issues that, if not corrected, might jeapordize the success of payment reform. The Commission has suggested methods to address these issues and hopes that HCFA will make the commitment to undertake this task in a timely manner.

Some of the issues that I will bring before you today may appear technical or arcane. But the level of the conversion factor, the accuracy and validity of the scale of relative work, the definition of payment areas, and other such concerns have major implications for physicians in different specialties and geographic areas and for beneficiary access to care. Because Congress enacted this legislation with the support of the affected parties, it now has a responsibility to ensure that implementation is consistent with its intent.

My testimony will focus primarily on the conversion factor and the scale of relative work. The Commission also has concerns related to practice expense, geographic payment areas, visit coding, and payment for anesthesia, electrocardiograms and to new physicians that I will mention briefly. The Commission expressed its views on several other issues, such as payment to nonphysician practitioners and assistants-at-surgery in its March report.[1] I have attached a more detailed summary of the Commission's views that I will submit for the record. The Commission is preparing a report in response to the NPRM and plans to submit it to the Congress in mid-July.

CONVERSION FACTOR

The Secretary has proposed implementing physician payment reform in a manner that would reduce fee levels by at least 16 percent by 1996 and, perhaps, considerably more. Coming on the heels of substantial fee reductions directed by budget reconciliation legislation in recent years, the proposed conversion factor could pose serious risks to beneficiary access. Medicare fee levels would be below Medicaid rates in many states.

Four issues are involved in the level of the conversion factor:

- the mechanism by which budget neutrality is achieved under an asymmetric transition to the fee schedule;
- the assumption concerning how physicians will respond to changes in Medicare payments;
- the assumption concerning physician billing for visits under a new set of codes;
- the assumption concerning how often physicians will bill less than the fee schedule amount.

Asymmetrical Transition

Under the transition specified in OBRA89, fees for undervalued services will increase more rapidly than fees for overvalued services will decline. The net impact of this asymmetry is a 2 percent increase in total outlays. To achieve budget neutrality, this 2 percent must be recovered.

This adjustment is complicated by two factors. First, the law specifies that any such adjustments be made on that portion of payment based on the fee schedule as opposed to that based on historical rates. In other words, the adjustment must be made entirely on the conversion factor. Second, only about one-third of services will be paid at the fee schedule amount in 1992.[2] This means that in order to reduce outlays by 2 percent, the conversion factor actually has to be reduced by 6 percent. While this adjustment achieves budget neutrality in 1992, it actually lowers payments

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[1] In comments to the Congress on the President's Budget for FY 1992 (dated June 24), the Commission discusses the proposal for payment for injectable drugs.

[2] For services that are more than 15 percent higher or lower than the fee schedule, conversion factor adjustments affect payment slightly.

in the out years as the fee schedule conversion factor plays a larger role in payment. That is, when the asymmetry reverses in later years, the reduction in the conversion factor is not reversed. As a result, the conversion factor will be substantially lower by 1996 than it would have been if the fee schedule had been implemented in one step.

Some have questioned whether HCFA has correctly interpreted the transition and budget neutrality provisions of OBRA89. In any case, however, the Commission believes that a 6 percent budget reduction was not intended by those who came together to agree on physician payment reform and is not sound policy. It recommends that the method of achieving budget neutrality be revised so that adjusting for the asymmetric transition achieves budget neutrality in each year of the transition.

The Commission has discussed several methods to attain this objective. For example, the adjustment for budget neutrality could be applied to the adjusted historical payment base rather than to the conversion factor. A reduction of 3 percent in the base for all services for which the historical base is more than 15 percent higher or lower than the fee schedule would offset the asymmetry without distorting the conversion factor. The Congress could consider a larger reduction for highly overvalued services than for highly undervalued services or an exemption of undervalued primary care services, especially those provided in rural areas. Alternatively, the Congress could reconsider the asymmetric aspect of the transition.

Behavioral Offset

The Secretary has proposed reducing the conversion factor by 10.5 percent to offset changes in physician behavior in response to fee changes. This figure assumes that 50 percent of fee reductions will be offset by increases in volume and changes in billing practices but that none of the fee increases will be offset. Due to the leveraging effect mentioned earlier, projection of a net volume increase in excess of 3 percent results in a 10.5 percent reduction in the conversion factor.

The Commission believes that this offset is far too large and has judged that a 1 percent reduction in fees is appropriate. In a situation of great uncertainty concerning behavioral response, the Secretary has made a worst-case assumption. Such an extreme assumption is particularly unwise when the Medicare Volume Performance Standard (VPS) mechanism is available to offset in the future any differences between actual and projected behavior. To the degree that the VPS cannot fully address such differences, the Congress might consider revising aspects of the VPS (for example, the maximum reduction from the Medicare Economic Index) at least for the update for 1994.

The Commission is also concerned about the impact of leveraging that triples the magnitude of the adjustment to offset changes in behavior. It recommends that the adjustment be applied to payments for all services rather than just to the conversion factor.

New Visit Codes

HCFA's budget neutrality calculations required a projection of the proportion of evaluation and management services that will be billed under each of the newly revised visit and consultation codes (often referred to as "the crosswalk"). Since these services will comprise more than 35 percent of Medicare outlays, the assumptions on which these projections are based can have a large impact on the conversion factor. Regrettably, HCFA had little data to guide it.

To demonstrate the sensitivity of the conversion factor to this assumption, the Commission simulated an alternative series of assumptions. Basing the assumption on data from various log-diary surveys of physicians results in 13 percent lower projected outlays for visits (and thus a conversion factor 5 percent higher) than predicted by HCFA. This exercise is suggestive of the degree of uncertainty in projecting billing patterns for new codes.

The Congress may want to create a process to adjust future conversion factors based on actual billing experience. In contrast to some other assumptions, these projections are relatively easy to

verify because physicians' billing patterns for visits have been relatively stable over time. The Congress could direct HCFA to revise the conversion factor in the future if the pattern of visits differs appreciably from the projection.

Bills Lower than Fee Schedule Amounts

Currently, a significant minority of claims are billed for amounts less than prevailing charge screens. While the additional information available to physicians on the level of Medicare fee screens may reduce the frequency with which physicians bill less than the fee screen, it is unlikely to eliminate these instances. HCFA assumes, however, that under the fee schedule, all bills will be for the fee schedule amount or more. This unrealistic assumption leads to the conversion factor being set too low. As in the case of visit projections, the Congress could direct HCFA to revise the conversion factor in the future to reflect differences between the projection and actual experience.

RELATIVE WORK VALUES UNDER THE MEDICARE FEE SCHEDULE

Although much of the initial attention on the NPRM has focused on the conversion factor, distortions in the scale of relative work also threaten to undermine the success of physician payment reform.

The medical community generally has accepted the payment reform, even with decreases in relative payments for many services. There was an expectation by all parties, however, that payment would be based on an accurate scale of relative work. We now find ourselves in the position of being six months away from implementation of the Medicare Fee Schedule with many of the values for physician services not accurately reflecting the work involved in providing them.

The Commission has just completed an evaluation of the scale of relative work that was ultimately incorporated in the NPRM. In addition to assessing the methodology of the Hsiao study and comparing its results with other relevant research, the Commission sought and received comments from numerous specialty societies and convened a panel of physicians representing 41 specialties to review outstanding issues and methods for resolving them. This meeting was extremely helpful in assisting the Commission to develop timely approaches for refining relative work values for the Medicare Fee Schedule.

Just two weeks ago, the Commission heard testimony from organizations representing clinicians and beneficiaries. Besides their strong criticism of the way in which the conversion factor was calculated, many expressed concerns about distortions in relative work values. These distortions affect relative work values for a broad range of services (particularly invasive and evaluation and management services) and are readily apparent to practicing physicians. Unless they are corrected, physicians will face inappropriate financial incentives and be paid inequitably. We have to be concerned that such an outcome could undermine physician acceptance of payment reform.

Fortunately, the problems underlying the scale of relative work are amenable to solution. In the Commission's July report on the NPRM, we will include recommendations for specific refinements in payment policies, codes, and relative work values. I would like to take this opportunity to highlight the reasons these refinements are needed and the types of problems they address.

> **Invasive Services.** Invasive services are paid in one of two ways: as surgical global services or as nonglobal procedures. The important difference between the two is that a surgical global fee includes payment for most services provided within several months of the operation that are related to the underlying condition for which surgery is performed, while a nonglobal procedure fee covers only those services directly related to the performance of the procedure itself. For nonglobal procedures, physicians are allowed to bill separately for services related to management of the underlying condition.

In order to assure equitable payment under the Medicare Fee Schedule, HCFA must establish a clear policy that specifies which invasive services should be categorized as global and which should be nonglobal. The NPRM does not include such a policy.

Invasive services must be categorized properly, both to permit equitable payment rates to be set and to ensure consistency and clarity in billing. Payment will be inequitable if services that are usually performed on patients with substantially different underlying conditions are categorized as surgical global services rather than as nonglobal procedures. In such cases, the work included in the global fee can vary considerably, yet the payment is fixed. For example, the NPRM treats needle biopsy of the lung as a surgical global service. Thus, a physician who performs this procedure on an unstable patient with AIDS and expends considerable work managing his or her underlying disease for the following 90 days (including possible hospitalization and complex treatment) will receive the same payment as a physician who performs a needle biopsy on a patient with a benign, asymptomatic lung nodule who requires no further treatment. If these types of invasive services were classified as nonglobal procedures rather than as surgical global services, payment could more accurately reflect the work involved.

In the fee schedule, closely related services should be categorized similarly. Otherwise, physicians will have difficulty interpreting relative work values and will be confused about appropriate billing. For example, in the NPRM a burr hole for evacuating a hematoma is categorized as a surgical global service while a burr hole for implanting a ventricular catheter is a nonglobal procedure. The four-fold difference in relative work values for these services results from their differing classifications, but it appears irrational if one is not cognizant of the differences in the services included in each fee.

Relative work values for invasive services included in the NPRM require further refinement not only because services may currently be classified incorrectly, but because HCFA did not define the components of its global and nonglobal payment policies in time for Professor Hsiao to use them in assigning work values to invasive services. HCFA has defined these policies in the NPRM (specifying what services before, during and after the procedure will be included in the payment), but the Hsiao work values included in the NPRM are not necessarily consistent with these policies. Because of this problem, all nonglobal procedures (other than endoscopies) are substantially undervalued in the NPRM. The relative work values for these services reflect only the work involved in performing the procedure itself, whereas the payment is intended to cover all services directly related to the procedure that are performed within 30 days.

Evaluation and Management Services. The relative work values for evaluation and management services in the NPRM result in a pattern of payments that does not account for differences in the effort (work per unit of time) involved in providing different types of visits. This implies that the same effort is involved in performing a consultation on a patient the physician has never seen before and in a routine office visit with an established patient. Such a fee structure intuitively does not seem accurate to physicians. Moreover, it undervalues shorter visits, resulting in underpayment of both surgeons and family physicians. After reviewing the NPRM, family physicians have begun to question how a reform that was to place greater value on evaluation and management services could result in decreases in payments for lower level visits. The Commission is also concerned that the payment structure included in the NPRM could create incentives for both upcoding and inappropriate use of services.

The Commission has concluded that available empirical data on relative work values for evaluation and management services cannot by themselves provide an adequate basis for payment under the Medicare Fee Schedule. Separate studies by Professor Hsiao and the Commission each provide results that lack face validity. Nonetheless, they suggest the form that a reasonable policy should take. Because of the importance of getting the values right for EM services--which will account for over 35 percent of physician expenditures under the

Medicare Fee Schedule and will affect those physicians slated to benefit most from payment reform--HCFA should place a high priority on taking the additional steps to design an appropriate fee structure before the fee schedule is implemented. Additional research is not required. In its July report on the NPRM, the Commission will specify the elements of a policy that would result in appropriate payments for these services.

Medicare Adjuster. Considerably more work is involved in providing certain services to elderly or disabled patients than to patients in the general population. For example, the global service for removal of an ovarian cyst entails twice as many postoperative hospital visits, on average, for an elderly Medicare patient than for a 25 year-old patient (the "typical" patient described in the Hsiao study). Because of these differences, refinements will be required to tailor the Hsiao study scale of relative work to the Medicare population. The Commission recommends that a Medicare adjuster be developed that would increase the relative work value for the services to which it is applied by a fixed percentage. This adjuster would be applied to services in which: (1) the typical patient is not a Medicare patient; and (2) substantially more work is required to provide the service to a Medicare patient than to the typical patient.

The problems I have described thus far affect broad categories of services. Some of the other inaccuracies in relative work values that appear in the NPRM come from problems specific to individual services.

Vignettes and Fitness-to-Rate. The Commission has identified a number of services whose relative work values are inaccurate because they are based on vignettes (clinical scenarios) from the Hsiao study that are not representative of the typical service provided under a given procedure code. Others are inaccurate because they are based on estimates of work by physicians who rarely, if ever, perform the service. These problems are not uncommon, affecting as many as 10 percent of the services provided by some specialties.

CPT Codes. Refinements in the scale of relative work will require not only changes in work values, but also changes in some of the codes that are used to describe physician services. Under the Medicare Fee Schedule, payment will no longer vary to accommodate regional and specialty differences in the use of codes. Thus, CPT codes that are ambiguous or that encompass a broad range of services entailing substantially different amounts of work will need to be revised if they are to provide a sound basis for equitable payment.[3]

Many of the distortions in the scale of relative work can be corrected without further research. Much could be accomplished by properly structured panels of experts (including clinicians, payers, beneficiaries, and health services researchers) that are provided with available data. Face validity could be assured if, as a final step, physicians in each specialty were given the opportunity to review the reasonableness of relative work values assigned to their services and to suggest refinements in a "budget-neutral" process designed to minimize any potential for gaming. Refinements in the coding system will meet the needs of the new payment system if clear policy goals are established that provide a framework for consistent coding decisions.

The key to successful resolution of the problems I have described in the scale of relative work is acknowledgement that these problems remain and a commitment to their solution in a timely manner. The Commission is concerned that many of the problems that need to be corrected are the same ones that were identified in many evaluations of Phase I of the Hsiao study. When the Commission recommended that payment reform legislation be enacted, it assumed that these problems would be resolved prior to implementation. The fact that they still exist diminishes our confidence in HCFA's commitment to resolve them.

[3] For example, the code for excision of a supratentorial brain tumor encompasses operations lasting from two to ten hours. But all physicians who use this code do not provide the same mix of services. Some physicians only use the code to bill for operations only at the low or high end of the range of work.

A number of the refinements in the scale of relative work could be ready in time for initial implementation of the fee schedule. Modifications made after publication of the final rule should be incorporated into the scale of relative work by January 1993. Decisions about methods to be used to update relative work values should not be made until we learn what approach works best in refinement. The NPRM describes several alternative processes for revising relative work values. Even more important than who does the updating is how it is done. HCFA will need to develop a clear policy on the methods to be used in updating work values.

OTHER ISSUES

The Notice of Proposed Rulemaking outlines the direction HCFA will be taking on other important policy issues such as practice expense, geographic payment areas, visit coding, anesthesia payment issues, payment for electrocardiograms and to new physicians. The Commission commented on most of these issues in its most recent annual report and I will touch on them only briefly here. I will also submit for the record the Commission's views on other fee schedule issues. The Commission recognizes that, in some cases, its preferred policy would require legislation and such alternatives were appropriately not addressed in the NPRM. We raise these issues here, however, to highlight future directions for reform.

Practice Expense

In the NPRM, HCFA proposed a site-of-service differential that reduces payment by 50 percent of the practice expense component when a service is provided outside the office setting. While the Commission is supportive of HCFA's efforts to apply a resource-based approach to its determination of practice costs, this proposal ignores the substantial variation in direct costs across services. The Commission has estimated that while the mean differential is 61 percent, the differential ranges from 8 to 97 percent. Until HCFA is prepared to apply service-specific differentials (or differentials specific to categories of services), a smaller differential would be more appropriate. The Commission also believes that the differential should be applied by both increasing payment for services provided in the office and decreasing payment for services provided in other settings.

Geographic Payment Areas

The NPRM makes clear HCFA's intention to maintain the current payment localities under the Medicare Fee Schedule, with the exception of the creation of statewide areas for Oklahoma and Nebraska. In its 1991 report, the Commission recommended using statewide payment areas in all states except the 15 with the highest degree of within-state variation in input prices.[4] This would result in 94 payment areas in the continental United States compared with 237 current localities.

The Commission recommends this policy because it captures input price variation across counties as well as current payment localities, but it does so with far fewer boundaries. It also avoids large payment differentials at state borders by allowing some intrastate variation in states with the highest price variation. Moreover, unlike the current locality boundaries, the recommended areas do not divide counties. This and the smaller number of areas substantially ease the development of accurate data to measure the Geographic Adjustment Factor. And because it is based on familiar geographic units, it also has the advantage of conceptual and administrative simplicity.

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[4] In each of these 15 states, up to five payment areas would be created by metropolitan statistical area (MSA) categories: more than 3 million; 1 to 3 million; 250,000 to 1 million; fewer than 250,000; and nonmetropolitan. The 29 MSAs that cross state borders will be considered to fall entirely within the state that includes the largest percentage of the MSA's total population.

Coding for Evaluation and Management Services

Although the changes in the codes physicians use to report evaluation and management services are clearly needed, the Commission cannot endorse the revised visit coding system that HCFA has proposed in the NPRM. In the Commission's view, the complexity of this system might send mixed messages to physicians, compromising the goals of coding reform. The results of HCFA's pilot study have not alleviated these concerns. The data do not suggest that the new system will be used more uniformly than the current visit codes.

The assumptions made by HCFA concerning use of the new codes suggest that it does not believe that physicians will use them according to the typical times in the levels of service. This suggests either that HCFA projects substantial upcoding or that the content descriptor and the typical time in each code are not congruent. If either is true, the relative work values assigned to the new codes (which are based on the relationship between work and time) will not be accurate or equitable.

Anesthesia Payment Issues

HCFA has proposed eliminating the use of anesthesia time units. This reflects the agency's concern that start and end times for anesthesia services are difficult to determine and that payment for actual time is inconsistent with the way Medicare pays other physicians.

In its 1991 report, the Commission recommended continuing the use of actual time after finding other alternatives, including that described in the NPRM, either inequitable or not operational. Development of a better operational definition of anesthesia time and more rigorous procedures to validate time would best address criticisms of current policy.

Payment for Electrocardiograms

Under OBRA90, Medicare will no longer pay for interpretation of electrocardiograms when performed in conjunction with a physician visit. To implement this provision in 1992, HCFA has proposed increasing payments for some visits to compensate physicians for the work involved in interpretation. Since most EKGs are done by a few specialties, this approach would be inequitable. A bundling method that is more consistent with the principles of a resource-based fee schedule is needed. The Commission plans to examine alternative methods of bundling EKG, laboratory, and procedural services with visits to determine whether a satisfactory method can be derived.

While equitable methods for bundling are being developed and assessed, the Congress should modify OBRA90 and pay for EKGs separately from visits at the final resource-based price for both the professional and technical components. To avoid reducing payments for other services by paying for all EKGs (albeit at a lower price), the transition to final fee schedule values should be accelerated for procedures that are substantially overvalued and which have not already been reduced through the overvalued procedure provisions of OBRA89 and OBRA90. To address overutilization of EKGs, HCFA should foster development of practice guidelines for the test and should profile physicians' practice patterns and provide educational feedback.

Payment to New Physicians

Under the Medicare Fee Schedule, new physicians will continue to be paid less than their colleagues already in practice. The Commission has long stood by the principle that physicians should be paid the same when providing the same service. Provisions that pay new physicians a discounted fee clearly violate this principle and the Commission has consistently opposed their adoption.

PHYSICIAN PAYMENT REVIEW COMMISSION

ADDITIONAL COMMENTS ON IMPLEMENTATION OF THE MEDICARE FEE SCHEDULE

The Commission commented on many of the issues raised in the Notice of Proposed Rulemaking in its 1991 *Annual Report to Congress*. A summary of the Commission's views is provided here and relevant chapters of the 1991 Report are noted.

Payment Policy for Surgical Global Services and Nonglobal Procedures (Chapter 2)

The surgical global service policy proposed by HCFA in the NPRM is broader than that proposed by the Commission. It has a longer preoperative timeframe (30 days) and, unlike the Commission's policy, includes surgical services related to complications which do not require return trips to the operating room.

The latter provision may compromise access to care for seriously ill patients. Many complications are not under the surgeon's control, but are due to the patient's underlying problem(s). Thus, the work involved in providing services related to complications should be accounted for in the surgical global fee.

The Commission recommends that HCFA not include these services in the surgical global service. If it does so, equitable payment will require the development of a "complications modifier", which would increase payment for all operations to which it is applied by a fixed percentage.

The Commission supports the intent of the nonglobal procedure policy proposed in the NPRM -- all pre/post services directly related to the procedure are included in the procedure fee, but physicians can bill for services related to management of the underlying condition separately. The Commission is concerned, however, that HCFA would implement this policy by denying payment for all visits provided within 30 days of the procedure unless a documented, separately identifiable service is furnished.

Most visits provided 15 to 30 days after a procedure are related to management of the underlying condition rather than to the procedure itself. Therefore, a policy that requires physicians to submit additional documentation to be paid for visits in this timeframe would be unnecessarily burdensome (if physicians provide the necessary documentation) or inequitable (if they decide it is too much of a "hassle" to submit the documentation or if they submit it but payment is denied). Moreover, it could discourage physicians from providing visits that are important for medical care. The Commission recommends that HCFA's policy be revised so that the timeframe is 15 days rather than 30 days.

Practice Expense (Chapter 3)

While HCFA has proposed practice expense relative values based on historical charges as specified in OBRA89, the Commission continues to support basing the practice expense component of the relative value scale on estimates of resources. It has developed and tested the feasibility of a resource-based method and will refine it based on additional analysis and discussion with interested parties.

The method tested by the Commission divides practice expenses into two categories, direct and indirect, as does common accounting practice. Direct costs are those that are clearly identified with the delivery of a service, such as the time a nurse spends assisting the physician during an intermediate office visit or the medical supplies used in setting a fracture. Indirect costs, such as rent, utilities, and management costs, are those that cannot be traced directly to any particular service. Data from national surveys of physicians have been used to split practice expenses into direct and indirect shares.

The Commission will issue a report later this year that includes a more detailed discussion of the methodology used, the data collected, and simulations of changes in the pattern of Medicare

payment. It expects the report to stimulate discussion on the limitations of the OBRA89 method and on refinement and elaboration of the resource-based approach.

Malpractice Expense (Chapter 4)

As with practice expense, the OBRA89 method of calculating the malpractice expense component of the relative value scale is not resource-based and has several deficiencies that lead the Commission to call for its revision. Under the OBRA89 method, payment for a given service will be the fraction of the 1991 national average allowed charge that corresponds to the fraction of physician revenue used to pay for liability insurance.

Since the same malpractice expense fraction is used for every service provided by physicians in a given specialty, the OBRA89 method does not differentiate among services that expose physicians to different levels of risk. Moreover, averaging across specialties will result in systematic underpayment to physicians who perform high-risk procedures.

The Commission supports basing the malpractice expense component of the relative value scale on estimates of the risk of service (ROS). It has developed and tested the feasibility of such a method and will refine it based on discussion with interested parties.

The ROS method bases payments on differences in the service's risk and the overall premium confronting the average physician. As a result, relatively more premium dollars are assigned to higher risk services than to lower risk services. The additional premium dollars paid by physicians in higher risk classes would be spread over the higher risk services they provide--the same services that place these physicians in higher risk classes.

The ROS method would reduce the payment distortions that will occur under the OBRA89 method. It is also easier to update, an important advantage since malpractice premiums often change substantially.

Paying Nonphysician Practitioners Under the Medicare Fee Schedule (Chapter 10)

Under current law, payment for most services provided by nonphysician practitioners (NPPs) is limited to a percentage of what physicians are paid for the service. Under the proposed rules, these percentage differentials will continue. The Commission also recommended continuing the present policy of differential payment. The differentials should, however, be based on estimates of differences in the resource costs required to provide the service. Separate differentials should be calculated for each category of NPP.

For the work component, the differential should reflect differences in investments in human capital: tuition expense and foregone earnings. For example, the work component for physician assistants would be valued at 87 or 75 percent of the physician level, depending, respectively, on whether the high rates of return that physicians receive on their training are applied to NPP training as well or whether rates of return that other professionals with postgraduate training receive are applied.

The Commission recommends no differentials for practice expense since it is assumed that NPPs and physicians face similar rent, supply, and personnel costs when providing a given service. The differential for the malpractice component should reflect premium differences.

HCFA has proposed that modifiers to CPT codes be used to identify services provided by NPPs billing independently. It is the Commission's view, however, that specialty-specific modifiers should be used to identify all services provided by NPPs.

The Commission also has concerns about HCFA's intention to continue payment at the physician rate for services provided by nonphysicians under the "incident to" provision. The Commission has recommended that when physicians bill for evaluation and management services provided by NPP employees, these services should be paid at the NPP, rather than the physician, level.

Finally, the NPRM notes HCFA's intention to pay nurse practitioners and physician assistants at the lower of the specified fee schedule percentage or the reasonable charge as determined under the customary, prevailing and reasonable methodology. This system will be burdensome to carriers and difficult for practitioners and beneficiaries to understand. The Commission therefore recommends that payment be based solely on the fee schedule percentage.

Payment to the Anesthesia Care Team (Chapter 11)

HCFA has noted problems with the phase-in of a provision of OBRA90 that was intended to raise payment to nonmedically directed certified registered nurse anesthetists (CRNAs) to the physician rate by 1996. Because the law specified specific dollar amounts for the CRNA conversion factors and the overall conversion factor is now lower than anticipated, current law will result in higher payments to CRNAs than to physicians. It also will result in distorted relative payments between nonmedically directed and medically directed CRNAs. The Commission recommended changes that would mitigate these distortions in its 1991 report.

The Commission is pleased to note that HCFA intends to change the current policy that creates a disincentive for anesthesiologists to supervise student CRNAs. The new policy permits full payment for only one procedure regardless of whether a resident or student CRNA is being supervised.

Payment to Assistants-at-Surgery (Chapter 12)

Under OBRA90, the Medicare payment to physicians who serve as assistants-at-surgery was reduced from the traditional 20 percent of the principal surgeon's payment to 16 percent. Results from Phase II of the Hsiao study, however, suggest that the 16 percent rate is lower than estimates of the resource costs. When combined with the recent and anticipated reductions in payments for surgical procedures, the 16 percent rule may make it difficult for surgeons to recruit assistants.

The Commission recommends basing payments to assistants-at-surgery on resource costs. Until resource-based relative values are developed for more procedures, it would be appropriate to return payments to assistants-at-surgery for all procedures to 20 percent of the surgical payment under the Medicare Fee Schedule.

Chairman STARK. Thank you very much. Mr. Moody.

Mr. MOODY. On the behavioral response, what does the literature say? Dr. Wilensky said that observed behavior in the past shows that there is behavioral response when prices are constrained. Can either of the three of you elaborate on that experience, starting with Dr. Wilensky, as you referred to in your testimony?

Ms. WILENSKY. Yes. There is no question that this is an area in which there is both mixed evidence and not as hard scientific evidence as we would like. HCFA has traditionally, for the last 10 to 15 years, used a 50-percent behavioral offset in the face of Medicare price reductions. We believe this is consistent with what we have observed. It is what the actuaries believe has occurred.

I would like to point out, in terms of 1990, when we calculated the first of the volume performance standards, we included a 50-percent change as well to account for behavioral response due to reductions that were included in the previous year's legislation. Had that not been the case, instead of having a 9.1-percent volume performance standard, we would have had a 7.4-percent volume performance standard. As it happened, expenditure increases were actually 10.5 percent.

I would also like to say that CBO has, over time, come to accept the 50-percent behavioral offset in their projections. A few years ago they had used 30 percent. They then used 50 percent with a 6-month lag. They are now, in fact, using 50 percent with no lag.

Mr. MOODY. No lag at all?

Ms. WILENSKY. No lag at all. There have been a few studies done. One that I think probably the panel is aware of, although it has been cited as having a number of flaws, indicated a somewhat greater than 50-percent behavioral offset in terms of the losers, and a 30- or 35-percent response for the winners. This methodology, although I know PhysPRC has said is somewhat coincidental, turns out to be consistent with their 1 percent versus our 3-percent volume change.

So we believe that there is, in fact, both in terms of what we have historically projected and found consistent with CBO practice and with at least some empirical evidence, indication that there are volume changes.

These changes can be just in terms of how one codes. They can be changes in terms of ancillary services. They can be changes in terms of the number of assistants at surgery that occur. They can be patient-demanded visits.

What we are concerned about is, if changes occur in any of these dimensions, expenditures are affected. And when you are concerned about budget neutrality, it is overall expenditures that you are concerned about. We do recognize that volume changes can occur in many places.

Mr. MOODY. So you are saying that if fees are constrained 10 percent, then volume would go up by 5 percent? When you say 50 percent, that is what you mean?

Ms. WILENSKY. It is in terms of the savings that would have occurred.

Mr. MOODY. OK.

Ms. WILENSKY. Let me give you an example. If a physician would have $100,000 of revenue as a result of Medicare, and the fee

changes that are proposed assuming no behavior change would have produced $90,000 in revenue, there will be——

Mr. MOODY. Approximately $5,000 made up——

Ms. WILENSKY. Right, exactly.

Mr. MOODY. That is what you are saying, OK. And you do say it is asymmetrical in the sense that those who have their fees—the physician who had $100,000 would now make $110,000, let us say, if no volume change. He would only reduce his activity not 50 percent, but less than 50 percent, so the overall impact would be a budget increase, is that what you are saying?

Ms. WILENSKY. There are two asymmetrical effects. One was deliberately put in the payment reform to try to help the winners faster than the losers. That is, you come into the fee schedule faster if you are going up than if you have to reduce your fees. That is one asymmetrical effect.

Mr. MOODY. That is one asymmetrical. That is a program design?

Ms. WILENSKY. That is a program design. The other one is by an assumption, although as is always the case in a proposed rule, we welcome comments suggesting other ways to look at it.

We have, in fact, assumed only a response from the losers and no response from the winners, because those who are gaining in terms of fees, primarily family practitioners and general practitioners, are frequently so pressed for time and have so many patients that they are not likely to either cut back the number of visits they are providing or take more leisure. Both are theoretically possible, but we thought practically, in fact are not likely to occur, given the pressures that we know exist on these family practitioners.

Mr. MOODY. So that is a budget up-push, because they would get more for the same work——

Ms. WILENSKY. Right.

Mr. MOODY [continuing]. And you don't expect them to scale back because of the type of practice they are in.

Ms. WILENSKY. Although again, we would welcome comments and evidence that people feel that——

Mr. MOODY. OK. Dr. Eisenberg, do you want to comment on the literature or the evidence or the design?

Dr. EISENBERG. Well, I would be pleased to. As an editorial, I would just comment on the fact that the PPRC tries whenever possible to base its policy on the best available health services research. In this case, we had to go pretty far to find some research that we could rely upon.

Also as an editorial, let me just compliment this committee and the Congress for having incorporated the Agency for Health Care Policy and Research into the same legislation that resulted in the Medicare fee schedule. I think that more health services research of that sort and that done by HCFA hopefully, in the future, will give us better data.

But here is what we know: By and large the literature is ambiguous. It suggests that physicians probably do increase their volume for some services when the price goes down to compensate for that decrease. But it is very unpredictable which services those will be, and it is very unpredictable how much the increase will be.

And the converse is the case. It is likely that physicians will decrease their services some when the price goes up, but which services and for how much is very uncertain.

There is some literature in this area that has been published. There was a conference, for example, earlier this year that concluded that the data is too ambiguous for one to really rely upon for making policy.

So to some extent, we are shooting in the dark. The best study—and even it is ambiguous—is one that the Health Care Financing Administration and others have used to support the 50 percent behavioral offset.

The study analyzed data from the late 1970s in Colorado, when there were fee changes in both directions. It found that physicians who had a decrease in their fees overall had a volume offset of over 50 percent. And as Dr. Wilensky has said, those who had an increase in their fees had a volume offset of about 35 percent.

Mr. MOODY. Let me just cut you off. I just want to give Dr. Nelson a chance, and I see my time is running out. Dr. Nelson.

Dr. NELSON. Thank you. I think that the information on that particular part of cost containment was very thoroughly summarized. But it is important also to realize the other efforts to try and contain volume by elimination of unnecessary services, studies of geographic variations, effectiveness research, and the development of practice parameters to try and identify the most cost-effective way for a doctor to solve a problem.

That may have a much more important impact on volume than altering the payment system. That is the reason why we wish to avoid an assumption at the front end, when the outcome is influenced by so many other factors.

Mr. MOODY. But you would agree there has been evidence of some volume reaction in the past?

Dr. NELSON. I think the evidence was accurately summarized, and we wouldn't argue with what was cited.

Mr. MOODY. OK.

Dr. NELSON. But there is still a lot of confusion and questions about it as each of the panel members said.

Mr. MOODY. Thank you.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you. I think we will go back to where we started. Each of you is citing the fact that you have couched your assertions in the best evidence available. The AMA, I think, can take heart by some of the words you used to couch your assertions.

Let me ask you this, John. You assert that a lot of work needs to be done in terms of the relative work values. We have 6 months before the implementation of this fee schedule. How do you suggest we get those appropriate refinements based on that requirement, and do we need them?

Dr. EISENBERG. We think we do need them, and a large part of our answer will be on your desk in July, with a report from the Commission that gives specifics about how many of these corrections can be implemented.

With the report coming out in July, there should be plenty of time, we think, before the new fee schedule has to be implemented to work on these. We believe that the research that has been done

in these areas does provide us with the foundation for change, and that we can work together at getting expert panels and using the Commission and HCFA resources to solve those problems.

We think it can be relatively easily accomplished.

Mr. McGRATH. The word access, or lack of it, is something that is of great concern to all of us. Dr. Nelson, in my area of the country, about 75 percent of my hospitals are filled with Medicare beneficiaries. If a doctor didn't take a Medicare patient, or didn't provide access to care through Medicare, they wouldn't have a practice, because that is all there is.

On the other hand, I can see some places in some rural States and rural areas where you could make that kind of a judgment, based on hassle and the fact that you can't make it on Medicare reimbursement rates.

I know some of you have said there is an access problem. Gail, how do you feel about access in terms of this relative value scale? Is it going to affect access in any way, shape, or form? John, I would ask you to answer the same question.

Ms. WILENSKY. As the chairman indicated, we do not believe that access at the present time is a problem. Participating physicians and acceptance of visits on assignment is at an all-time historical high.

When you make as many changes to a fee schedule as we are making in the relative value scale, it would be imprudent not to watch the effects that you are producing, and we are planning to do so in a variety of ways.

We will be monitoring, through our common working file, part A and part B expenditures to see any change in access. We will also be looking at participation and assignment rates as we make this change to the new fee schedule.

Starting in the fall, we will be implementing a survey that we have been piloting where we will interview a sample of some 12,000 elderly people three times a year. We will ask them a variety of questions, including changes in their ability to see a physician and any other difficulties in access.

We don't believe there will be a problem. We do believe that when you make as many changes as are suggested here that it is important to monitor to make sure that access isn't affected. And we believe we have a system in place that will allow us to do that.

Mr. McGRATH. John.

Dr. EISENBERG. I think the way we like to think of the question is whether or not choice of physicians or site of service is going to be restricted for Medicare beneficiaries. There are two key ways of looking at that.

One is the short-term issue. There may be doctors who choose not to see Medicare beneficiaries who would have before. But we don't think that that is going to be a very large response. We think that the most important issue is really the long-term effect of the Medicare fee schedule. Will doctors, because of the change in geographic payments, go into areas where they would have not gone before? And will doctors, because of the change in payment across specialties, go into specialties that they would not have gone into before? Will we, as a result of the Medicare fee schedule, get more

primary care doctors, and will we get more doctors in underserved areas?

We would like to be sure that the payment system as we see it implemented maintains the changes that would, in the long term, lead to more physicians in primary care specialties and more going into the underserved areas. And I think that, to us, is the most important issue on the access side.

Mr. McGRATH. You made a statement in your testimony regarding your ability' or lack of it, to actually look at what is happening out there, as opposed to making these guesses in terms of what may or may not be happening.

How close are we to having that kind of scrutiny?

Dr. EISENBERG. Well, we think we are a lot closer for at least two reasons. One of them is that the data bases that HCFA has been working hard to develop over the past few years are improving and will provide us with the capability of monitoring both access to care and physicians' response and utilization.

Second, we believe that the methods of profiling physicians to look at their individual practice patterns are improving, in part because the data bases are better. Additionally, we as a Commission, HCFA, and Congress will have a lot better ability to do the research that is going to be important to monitor access, which we just haven't been able to do in the past.

Mr. McGRATH. All of our reimbursement systems seem predicated upon baseline figures for years before. Do you envision that this relative value scale can be real-time in terms of the baseline?

Dr. EISENBERG. If I understand your question correctly, you are asking how long will it be before——

Mr. McGRATH. Well, the prior question was, how close are we to being able to monitor the actual practice? Now I am asking, can we, based on that answer, use this or change this conversion based on real-time figures, instead of some baseline that is 2 or 3 years old?

Dr. EISENBERG. Well, there will be a lag. So the data will not be immediately available of course. The bill has to be processed and paid, and the data has to be entered, and the tapes have to be available.

Perhaps I could turn to my colleague, Paul Ginsburg, and see if he has a comment about this.

Mr. GINSBURG. Well, I think with the development of the common working file by HCFA, we expect this lag—which has been terrible in the past—to be shortened substantially. It may not initially be as good as some other countries' systems are, as far as the prompt availability of the data on what they are spending and on what services, but I am anticipating substantial improvements.

Mr. McGRATH. The geographic areas that you are recommending to be reduced from 230 to 94, is that a generic kind of thing, or State by State, or region by region? How does that work?

Dr. EISENBERG. No, in most cases it is State by State. But in some States, there is enough disparity in cost within the State that we felt that those States needed to be divided up into sub-State areas. That is how we end up with 94.

Mr. McGRATH. And Gail, would you respond to that?

Ms. WILENSKY. Yes. I believe that the recommendation is that in 35 States there will be a single payment locality, and in the remaining States there will be multiple payment localities.

It is our intent that we consider different geographic areas at the conclusion of the transition, and not at the start of the transition. There is so much change, particularly in the States which have multiple localities, that we would not be able to have the transition occur and change to different localities during the same period. Therefore, we would wait until 1996 to make any changes.

The two exceptions that we have considered are two States, Nebraska and Oklahoma, that have specifically requested they go to single payment areas. They have provided us with indications that there is a majority of physicians in all parts of the State, including the urban areas that typically will lose under such a consolidation, that prefer a single statewide payment locality. We have indicated that in January of 1992, in these kinds of situations, we would make them a single statewide locality.

Mr. MCGRATH. Thank you. Let me just say in conclusion of my questioning that I think this has been good. I mean the fact that we have had this interchange, and we had an exchange of ideas here. It has been good and cleared up a lot in my own mind, and I hope it did for the rest of the panel. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, let us discuss again what seems to be the crux of the problem. I would be interested, Gail, in your reaction to Dr. Eisenberg's testimony.

Before you comment on it, as I read the materials, HCFA seemed to do this: Decide where it wanted to end up, translate that into a conversion factor relating to the behavioral offset. That is what you seem to have done.

Ms. WILENSKY. Well, may I respond?

Mr. LEVIN. Yes.

Ms. WILENSKY. Let me first respond to the second part, and then respond very quickly to the points that he raised.

What we have done, to the best of our ability, is to put out a proposed rule that we believe conforms as closely as possible to the statute as it was written, as guided by our lawyers. We do recognize that there are areas where there may be some differing interpretation.

We have sought advice from our counsel as to what the best reading of the law is. We have indicated in the proposed rule where we think there may be other alternatives. We welcome people to provide us with information.

We believe the statute, as now written, requires a transition that is asymmetrical, and that the way that we can adjust for that asymmetry is through affecting the fees that are inside the fee schedule and not across all fees—not that the other wouldn't be possible, but it would require legislation and it would also have some budget consequences.

In addition, our reading of budget neutrality was budget neutrality in 1992, not trying to recoup for some years later. Therefore, our actuaries provided us with their best estimate as to what it would take to get to budget neutrality.

Mr. LEVIN. It seems to me—let me just interject—it seems to me you have just said in rather larger form what I said, that everything here was bottom-line driven. You figured out——

Ms. WILENSKY. Of budget neutrality.

Mr. LEVIN. Yes. So there should be no effort, really, to defend the conversion factor and the behavioral offset, mainly in terms of research and what was likely to happen.

Ms. WILENSKY. Well, except I don't understand why you would draw that conclusion.

Mr. LEVIN. Because you decided where you needed budget neutrality for 1992. You decided what you thought would be the overall expenditures under RVS. You had to have a conversion factor that brought about that bottom-line figure, and that is exactly what you did.

Ms. WILENSKY. The notion of having a conversion factor which anticipates the behavioral change, yes. That is, we believe the conversion factor is the only tool we had available to us.

Mr. LEVIN. Well, this is another way of saying—you didn't decide what the behavioral change or reaction likely would be and then factor it in. You decided what figure you needed to reach——

Ms. WILENSKY. But how would——

Mr. LEVIN [continuing]. And then factored in——

Ms. WILENSKY. But they are not independent. I mean, we didn't have in mind the expenditure without taking into account the behavioral response. The problem for the actuaries is to estimate, in the face of the fee schedule changes, what kinds of behavior will occur. In fact, the estimate is that without a behavioral response, the fee schedule would have been x-percent higher, expenditures would have been x-percent higher.

In order to account for this behavioral response, we have to build it into the adjustment factor. But of course, it takes account of what the behavioral response will be. It would have been a different conversion factor if, in the actuaries' best judgment, instead of 50–0, it had been 55–35, like the one Colorado study that was cited, or something else.

Similarly, we would have done something differently if the interpretation had been that the statute was not directing us to concentrate on the fees inside the fee schedule but to spread it over all fees, or to do what John had suggested, to consider doing it before all the fees are in. All of these are possible, but again, according to our counsel, not what the statute now specifies.

So it was, in fact, exactly because we were looking at the anticipated behavioral response. We had hours of discussion inside HCFA and with the Department arguing through what the right behavioral response would be. It was only after there was agreement on what the right behavioral response would be that a conversion factor was calculated to take that into account.

Mr. LEVIN. I do not think it is quite that simple or that way.

Ms. WILENSKY. Well, this whole business is not quite that simple.

Mr. LEVIN. There is, in terms of the adjustment retrospectively, there is a floor, is there, on how much we could adjust next year?

Ms. WILENSKY. There are several reasons that make the after-the-fact adjustment difficult, all of which with enough legislation could be changed.

Mr. LEVIN. All right——

Ms. WILENSKY. One of them is what you just referenced.

Mr. LEVIN. OK. So let us put it in simpler terms yet. Because of your concern about an after-the-experience adjustment, what you are doing is to increase a before-the-experience adjustment. Isn't that what you are doing?

Ms. WILENSKY. We always include in our estimates our best estimate of behavior change, as does CBO.

Mr. LEVIN. But we contemplated an after-the-fact adjustment. We would take into consideration the experience of the previous year, and we would reduce it.

Ms. WILENSKY. But that doesn't get you budget neutrality in 1992, and at least our reading is that budget neutrality is required at the start. If you try to recoup this, you can't impact what happens in 1992 until the 1994 period. And in fact, our view is, as it is now constrained by law, you will never get it all, because you will be applying a smaller update factor to a base that is bigger than it should have been.

And furthermore, you have in your volume performance standard a 5-year running average, which also will include this bigger base.

So the fact of the matter is, you won't get it out after the fact. This is not even counting the 2-percent lid that occurs early, which could be changed legislatively.

Mr. LEVIN. So I think what is being illuminated here is that we have essentially a budget-driven solution that is shaping the formulas, and not an assessment of need or likely experience that is driving the conversion factor here.

Ms. WILENSKY. Well, I agree with the first part, but I don't agree with the second.

Mr. LEVIN. Well, I am not saying that isn't the way it should be. I just want you to acknowledge that that is what has happened here. If we have to look at the statute again, we have to look at it.

We may decide to let this thing be totally or essentially budget-driven, but——

Ms. WILENSKY. I mean, by budget driven, I assume you mean that there is a directive to be budget neutral.

Mr. LEVIN. Here is what I mean.

Ms. WILENSKY. I mean, that is what is in the statute.

Mr. LEVIN. Here is what I mean. You decided there had to be neutrality in 1992.

Ms. WILENSKY. I don't think that we decided that. I mean, that is just not fair. Congress wrote the statute. We don't write the statute.

Mr. LEVIN. All right. Let me just finish. I was going to describe your interpretation of budget neutrality. But anyway, you decided where we had to come out——

Ms. WILENSKY. Budget neutral.

Mr. LEVIN. OK. You also, from there, then began to look at the fee schedules, and then you built a conversion factor in it that would reach budget neutrality.

Ms. WILENSKY. Yes. There are many parts in this very prescriptive statute that limit what we could do. In our view, it was the statute that required us to only focus on the fees that were inside

the fee schedule, and not to go across all fees, which is what causes the 3-percent multiplier.

Mr. LEVIN. All right. My time is up. You also decided that within the statute, you could not look at overvalued fees——

Ms. WILENSKY. It is our reading that that was, in fact, directed in the statute. Again, to the extent that there are alternative interpretations of the statute, we obviously welcome them in this comment period.

Mr. LEVIN. OK.

Ms. WILENSKY. That is what we believe the statute was directing us to do.

Mr. MOODY [presiding]. Just before we move on to Dr. McDermott, to pull out what I think is the answer to this, there are three or four things you had to do, and then some things you plugged in——

Ms. WILENSKY. Right. I don't want to make it sound like there are no policy decisions that we made. We did, but the things that you were referencing——

Mr. LEVIN. It sounds like——

Mr. MOODY. If you treat this as a four-cornered tent, one corner, one stake in the ground is budget neutrality, right?

Ms. WILENSKY. Right.

Mr. MOODY. Another stake in the ground is only one-third of the services being phased in, right?

Ms. WILENSKY. Right. That is in the first year.

Mr. MOODY. In the first year. The other stake is what? It is locked in, that you didn't have discretion over?

Ms. WILENSKY. The transition.

Mr. MOODY. Transition, OK. And then the fourth corner of this tent were the behavioral aspects that you made educated judgments on.

Ms. WILENSKY. Right.

Mr. MOODY. Is that an accurate way of summarizing this?

Ms. WILENSKY. That is correct.

Mr. LEVIN. My point is that the way this is set up, the behavioral adjustment is more a response to the other factors than it is something that was driven by solid evidence of any kind.

Ms. WILENSKY. It is, of course, the same kind of assumption we and CBO provide you with all of the time, including in each of our volume performance standards.

We don't frequently make a big deal about it, but as I mentioned earlier, when we provided the committee with volume performance standards, both the one we just did and the one in 1990, they also included an estimated effect of a 50 percent behavioral change.

Had that not occurred, the volume performance standard would have been lower, because there were savings provisions that had been enacted in the statute. We assumed, as we have in the past, that half of those savings would be offset by increased volume, and, therefore, the volume performance standard set was higher than it otherwise would have been.

Had that not happened, this year's recommended fee update of 2.2, which was 1½ points less than it would have been because expenditures in 1990 exceeded the MUPs would have been even lower, because instead of 9.1 in 1990, we would have had a volume

performance standard of 7.4. Now, as it happens, we would have hit the 2 percent ceiling and not have been able to make the full reduction.

I am only saying this to suggest that although you have not always been aware of it, the 50 percent behavioral change is something that the HCFA actuaries have used for a long time, and that in recent years, CBO also uses in its projections to you. So it is something normally not this explicit. We ask the actuaries to give us their best estimate of where we are going to be when the dust settles. You make your legal change and people behave as they will. We ask, "What is the outcome?" But it is not something new.

Mr. MOODY. Fine. Dr. McDermott has been patiently waiting.

Mr. LEVIN. Thank you.

Mr. MCDERMOTT. Thank you. I am one physician who thought payment reform was a good idea, and welcome the effort to redistribute what has gone on in terms of payment.

As I look at table one, and I really am directing my question to Dr. Wilensky and Dr. Eisenberg both, it makes common sense in that family practice and general practice go up. But there are two things that don't immediately make sense to me, and I would like you to try to explain them to me.

One, and maybe it is because I spent 20 years practicing the mother of all cognitive specialties——

[Laughter.]

Mr. MCDERMOTT. Psychiatry goes down 9 percent, otolaryngology goes up 2 percent, and if you look at the 5-year figures, the same disparity occurs.

The chairman raised the psychiatric question at the beginning, but he never gave you a chance to answer it, so I would like to give you a chance to explain why that apparent anomaly occurs in the system.

Ms. WILENSKY. We agree that it is an apparent anomaly. We are going back to try to determine whether there is anything we can see in the way any of the values were calculated. It was counterintuitive to us, also, that it would go down.

So I can only assure that between now and the time that the final rule is published in October, we will have taken the number apart to see whether or not there is anything about how the relative work values were constructed or the practice or the malpractice expense, because we also believe that it was counterintuitive.

Let me give you, as an example, something that also may seem counterintuitive. Why is it that the internists look so much different than the family practice and general practitioners?

Basically, these are estimates of how we think, on average, individuals in a specialty will end up. But what it really suggests is that internists, to the extent that they behave much more like general practitioners and family practitioners, will do much better than is suggested here. Internists that do a lot more testing and procedures and other higher-priced activities that makes them look more, for all intents and purposes, like medical specialists, will do less well. And that really is something that varies.

Again, these are just estimates. Because of the way the values are calculated, it will depend very much on what an individual

physician actually does, the actual services that individual performs. And again, to the extent that internists behave more like family practitioners and general practitioners, they will end up looking in their payments much more like them. To the extent that they do much more medical procedures, they will not.

But we agree that the psychiatrist value looks peculiar, and as I have said, we are going back to see whether there is anything that went wrong in the estimates.

Mr. McDermott. Can you explain the otolaryngologists going up? They are one of the surgical specialties, and they show a 2-percent increase on this table. That again surprises me.

Ms. Wilensky. Again, it is our estimate overall of what will happen. It will depend very much on the mix of services they do, and the frequency with which they were doing overpriced procedures. We will also go back, at your suggestion, and look at them as well as the psychiatrists. But we had already identified psychiatrists as an area that we wish to pursue further.

Any of the specialty areas that believe there is something inconsistent or anomalous ought to bring us information, data, and discuss these issues. That is what the public comment period is for, and we would welcome these inquiries.

Mr. McDermott. Dr. Eisenberg, do you have a comment on those two specialties, what you think from looking at them?

Dr. Eisenberg. Well, as an internist, I was confused when you were asking about the mother of all cognitive specialties, but I will leave that one alone. [Laughter.]

So yes, I think we were surprised that the results came out the way they did. The difference for internists, for example, is in part a result of what Dr. Wilensky has stated—that some internists do a large number of procedures. We are more concerned that these results are so different from the previously anticipated changes.

I don't personally know how much of that is because of the issue of the electrocardiograms that I raised earlier. At least part of it could be. But a large part of it, I think, is due to the fundamental issues that we have talked about before: the asymmetry and other factors affecting the conversion factor.

Ms. Wilensky. May I respond quickly? I don't think it is very much the EKG issue, which to my mind is more of a problem when there is an interpretation without a visit than it is building the interpretation into the visits.

There were several reasons why the values changed from those that were first published. One of them is, of course, that we were using 1987 data when the values were first published. These are now our most recent data. The other is precisely what you suggested, those early values did not include either a transition effect or a behavioral change, and those clearly did have an impact.

Mr. Ginsburg. I would like to point out to the committee that these tables from HCFA are showing the changes from where we are today to where we will be in 1992 and 1996. All the previous analyses, and the analyses the Commission still does, use as the base where payments were in 1988.

The reason we do this is that we regard many of the policy changes made by Congress in OBRA 1989 and OBRA 1990, such as overvalued procedures and the higher updates for primary care,

really as part of payment reform and the initial stages of the transition.

And I think it unfortunately makes these numbers very difficult to interpret and is one of the factors why they do look different. I think if you did these situations relative to a 1988 base, some of the primary care specialties might look somewhat better, and the surgical specialties might look somewhat worse than this table is showing.

Mr. McDermott. So you are saying it depends on when you pick the base?

Mr. Ginsburg. That is right.

Ms. Wilensky. We would agree with that. The changes that were made in the OBRAs during that period were to increase primary care only and to decrease the overpriced procedures, which were tipping the scales in the direction that the relative value scale was ultimately to go.

Mr. McDermott. Thank you very much.

Mr. Moody. Thank you. Mrs. Johnson.

Mrs. Johnson. Is there any plan to do better research on this issue of volume changes, and let me set my concern in the context of some recent discussions that I had with rural family practitioners, who see themselves, who accepted assignment, now no longer accept assignment, because to accept assignment means they have to go out of business.

Now, one of the things that they are talking about increasingly, and it very much reflects what PhysPRC talked about in their testimony with Dr. Eisenberg.

They are impressed by the new specificity of the coding requirements and the much greater detail of those coding requirements. And those coding requirements, because they are so much more complex and detailed, are much more burdensome to them administratively. They are receiving many more questions and denials. The delays in payments are much greater.

My sense from hearing them talk was that we are asking them to participate in a coding system that will give us the information we think we need about outcomes and efficacy of certain treatment patterns.

Now, that is legitimate for us because we need that information. But it may mean that you have gone to a system of coding complexity that is useful for us, but may appear to increase volume when in fact it is only differently describing what has been done in the past anyway.

I am very concerned about this volume increase, in part because it hits my State, which is a high-cost-of-living State—high fees, high costs, I mean corporate headquarters are moving out because housing is unaffordable. We are a State with very high cost wages, nurses, nurses' aids, technicians, office help, housing, cost-of-living index, you name it, it is ours.

So we are going to be very heavily impacted by this. And if the volume adjuster is, as I am beginning to suspect it is, in part related to different coding requirements that we are doing for good and legitimate purposes, then I hate to see that volume adjuster reduce reimbursements when actually the same care is being given.

Ms. WILENSKY. I think there may be a couple of different effects that you are referencing. The impact that I think your physicians may have been reporting thus far has to do more with what we usually term the hassle factor; that is, what our carriers do to make sure that care is medically appropriate.

It is an issue that we are trying to work on. We have a demonstration now in effect of providing more information to the physicians about what triggers an audit so they will know what is permissible in the hopes that that will have good, not bad, behavioral effects.

There is a coding change that will occur with this new payment reform. It represents a lot of effort on coding that has involved the AMA's CPT committee, the Current Procedure Terminology Committee, and will correct what we believe are a number of problems in terms of inconsistencies and unreliability in coding.

This whole area will provide researchers for many years to come, I am sure, with a lot of information in which to do research about volume changes.

In the end, we frequently look at expenditure patterns even more than the physical volume. We understand that looking at volume in terms of number of visits or tests can be so difficult. Usually, most research is done both looking at any physical measure of volume that is on hand, like visits or tests, and also expenditures and trying to determine how they relate to price changes.

So I don't think it has impacted our estimates of volume changes as they have existed thus far.

Dr. NELSON. May I respond also?

Mrs. JOHNSON. Yes. But just to respond for a moment to Dr. Wilensky's comment, it is interesting that coding changes will accompany this. I think it is important to recognize that since 1983 to the present, the coding volume has gone from something I think roughly around a half-inch—now I am not sure about where it started—but now it is several inches.

This issue of complexity of coding isn't just a hassle issue. It very much affects our view of volume, and often it distorts our view of volume. It is like volume of outpatient services, because we clamp down on duration of stay and intensity of care and so on and so forth in hospitals. We wanted outpatient surgery. It is cheaper.

I fear sheer volume as a factor driving reimbursement rates, and I guess my concern is (*a*), as I asked initially, what research are we planning to do to get a better handle on this, and (*b*), I would hope that you would move back toward the 1 percent from 3 percent, since this is going to have such a disparate effect on States. And if we have time, I would like to get into that disparate effect on States a little bit.

Dr. Nelson.

Dr. NELSON. I will be very brief and just say that the AMA has supported a need for physicians to more precisely describe their evaluation and management services, but we also understand that we have a major job to do in educating physicians on how to use that in a way that fairly and accurately describes the services that they have provided.

We in the specialty societies will be working very hard on an education program to make sure that that works. But it won't be easy, you are quite right.

Mrs. JOHNSON. And in terms of research planned?

Dr. EISENBERG. Let me respond for a second from the Commission's point of view. We have sponsored research already to look at the effect of fee changes on volume because we do have some experience from the fee freezes and from the overvalued procedure cuts.

Our conclusion is that the results are too ambiguous to base policy on and that it is hard to predict what is going to happen. We plan to continue to do that kind of research so that we can look at the effect of fee changes on volume.

Ms. WILENSKY. We think that a large role will be in monitoring the changes that occur as a result of these relative value scale changes. It will provide us with better information. It will certainly provide us with a more diverse experience than has ever occurred.

That does make research complicated. Researchers like to have one change and everything else stay the same. It makes it easier to attribute an effect. One of the problems that we will have is that we have so much change occurring. It will provoke arguments for a long time about precisely what effect is associated with what cause.

Mrs. JOHNSON. OK. Just briefly——

Ms. WILENSKY. But we will monitor——

Mrs. JOHNSON [continuing]. Before the red light goes on, Hawaii has one of the few medical insurance systems that provides universal access. Aren't you concerned that they will be one of the largest losers under this, at least according to those tables, that they have a loss of minus 6 percent, Minnesota has a gain of 6 percent. So the swings here—Nevada down 5 percent, New Hampshire up 5 percent—why? What is happening behind those numbers?

Ms. WILENSKY. The change effects need to be looked at relative to the overall change effects, which in this case are a minus 6 due to the transition, a minus 16 from the fees themselves, due to all of the changes. The total expenditure changes, of course, are much smaller. It is the minus 6 in 1996, not counting any outlay increases.

What happens is very much dependent on our best estimates, of the mix of physicians in that State, what those physicians will actually do, and how much those physicians have been billing relative to how much they will be able to bill in the future.

One of the points that is, I think, becoming clear to many rural physicians is that although they will gain relative to where they have been under the relative value scale, those rural physicians who were routinely balance billing may find themselves, because of the new balance billing limitations that started last year and will continue until 1993, with a mixed experience. They will gain in terms of what Medicare pays them. They may have some loss in their ability to balance bill over and above what Medicare pays them. But it is dependent on the mix of physicians and the kinds of services that they actually provide that determines whether or not a State will decline and how much they decline relative to the average.

Mrs. JOHNSON. I do find that the concern about Medicare fees and their adequacy is most intense in the rural general practition-

ers, and they do balanced bill, at least in my State they do, because it is the only way they can stay alive if they are general practitioners and primarily dependent on Medicare.

Ms. WILENSKY. They will gain.

Mrs. JOHNSON. Well, I am not sure whether they will. If they are in a State like Connecticut where the costs are high, if they are not allowed to balanced bill and their fees only go up a little bit or maybe on balance lose, I mean we are on the verge right now of losing a whole group of physicians that are in their fifties.

There are now physicians coming into my office that are in their thirties that are saying, I can't stay in this business if things keep going this way.

And when I look at the rural States that are going to lose under this, I am really concerned about just assuming the kind of volume factor you are assuming, even talking about a 16-percent cut that then we are going to offset by some other things.

I really would hope that we could be able to look at sample rural physicians' offices and see what is going to be the combined effect of the increases, the decreases, and see whether in fact this move to a relative value scale under the terms of our legislation, which were not terms that I was enthusiastic about, is really going to help or hurt.

I am not convinced by what is going on here today or by what I see in the field that the incredible disparity that we have allowed to grow over the last 10 years can be rectified through such a really modest change that is formula-driven and legislatively-driven.

Mr. MOODY. OK. Mr. Chairman.

Chairman STARK. Thank you, Mr. Chairman. Because I will have to leave for a few minutes, and I won't have a chance to thank the witnesses, I wanted to take this time to thank them for bearing with me as I vent my frustration on the system. I hope that the three groups can work quickly to resolve these problems.

Before the Chair recognizes my colleague from Maryland, Mr. Cardin, who has been waiting patiently, I would just like to make a couple of additional comments. To the extent the subcommittee would have to legislate or to the extent anyone cares about the Chair's concern of some of these peripheral issues, I would just like to quickly suggest to the witnesses in referring to PhysPRC's testimony that it is my hope that we can get back to the EKG issue and find a compromise that will be satisfactory, albeit temporary.

My experience, which is on the receiving end, is that I think I could now plug myself into the machine. I am not sure I have any idea what that piece of paper coming out is, but I am also sure that the variety of internists who look at it look at it in a way that hasn't changed from year to year.

Now, if something serious happened, maybe there would be a difference. But it does seem to me that there is some bundling that could take place here.

It makes no sense at all to take the anesthesiologists off a time scale. Averaging that, I think, could cause more problems than it resolves, and I think the Commission's suggestion that if HCFA is concerned about their gaming us and not keeping accurate time, Mr. Kusserow has a dozen people from his staff in the room today,

and they could probably figure out how to put these guys in jail if they can't keep the time cards accurately.

That is not a question for us to determine. If the law says you have to keep track of the time, let us figure out how to enforce the law and not throw them into averages.

I am going to have to argue with my good friend from Seattle about whether or not psychologists should get the same rate as psychiatrists for, say, analysis. I can understand that there is some difference in preparation for getting to the treatment of patients, and I understand there is some difference in the Commission's report, that originally they were about to suggest paying psychologists the same amount as psychiatrists.

The intervention of the fourth estate or the fourth branch of government seemed to have changed some minds. I would like to see some more parity there, and I hope that that could be worked out as the Commission originally was going to recommend.

The other suggestions of PhysPRC, I think, are well taken, and I hope that HCFA will listen to them. PhysPRC is indeed our expert, and the danger in not recognizing PhysPRC is that members of this committee will have to start to make those decisions. Then the medical profession will be in real trouble. [Laughter.]

Chairman STARK. The final thing is to ask whether the numbers are available at this point?

Ms. WILENSKY. I will hand it to you, or I can read it to you.

Chairman STARK. What I would like is starting in whatever would be 1991, what current law would be, and then for the aggregate expenditure.

Ms. WILENSKY. OK——

Chairman STARK. And then how the aggregate expenditure in that year would change under your proposed rules.

Ms. WILENSKY. All right. Under current law?

Chairman STARK. Yes.

Ms. WILENSKY. Do you want to start with 1991 or 1992?

Chairman STARK. 1991, if we could.

Ms. WILENSKY. OK, 27.13, 30, 33.2——

Chairman STARK. Wait a minute—30 is 1992? You are reading down?

Ms. WILENSKY. Correct.

Mr. LEVIN. Thirty——

Ms. WILENSKY. Yes. 33.2, 36.5 in 1994, 40.2 in 1995——

Chairman STARK. 40.2?

Ms. WILENSKY. Correct, and 40.4 in 1996.

Chairman STARK. OK. Now under your proposed rule?

Ms. WILENSKY. OK, under our——

Chairman STARK. Or is that your rules?

Ms. WILENSKY. OK. This is under current law as under our proposed rule. If we give no transition effect, which is what you had asked me initially——

Chairman STARK. This is the result of HCFA's proposed rules.

Ms. WILENSKY. Right.

Chairman STARK. OK. What would current law be without the rules?

Ms. WILENSKY. It starts the same, 27.3, 30.0 in 1992—1992 is not affected—33.7, 37.7, 42.3, 47.5. That is without the transition. If

there is no transition effect and no behavioral offset, 1992 is 31.2, 1993 is 35, 1994 is 39.2, 1995 is 44.0, and 1996 is 49.4.

Chairman STARK. Let me see if I have the starting block again. Going across, 27.3 or 13?

Ms. WILENSKY. Point three, excuse me. I read that wrong.

Chairman STARK. 27.3 is under your regs. Current law, I thnk I want to skip that. What you are saying is if you don't put the transition in, and if you don't have the volume adjuster, you would be what for 1991—I missed that?

Ms. WILENSKY. It is the same thing.

Chairman STARK. 27.3 across?

Ms. WILENSKY. Right.

Chairman STARK. So it would be 30 or 30 or 31.2——

Ms. WILENSKY. Right, that is correct.

Chairman STARK [continuing]. If we just did—and it would go up then 3.8 instead of 3.2 from 1992 to 1993 and it would go up 4 instead of 3 and we could figure out what the——

Ms. WILENSKY. And the total, if you wanted the aggregate across.

Chairman STARK. Yes.

Ms. WILENSKY [continuing]. With no transition and——

Chairman STARK. No behavioral adjustment.

Ms. WILENSKY. 6.9, to have no transition only. If no transition and no behavioral offset, a cost of $14.6 billion in the aggregate.

Dr. EISENBERG. Mr. Chairman.

Chairman STARK. 14.—it has to be more than that. Try again.

Ms. WILENSKY. It is 6.9 and 14.6; 6.9 just for the transition, the accumulated transition, is roughly $7 billion.

Chairman STARK. Yes.

Ms. WILENSKY. And the accumulated behavioral offset is 14.6.

Dr. EISENBERG. Mr. Chairman, may I ask a question? I think that that——

Ms. WILENSKY. Oh, that is—excuse me, the costs of the transition and the behavioral offset for the 5 years.

Dr. EISENBERG. That assumes the increase in behavior——

Ms. WILENSKY. Occurs as we expect.

Dr. EISENBERG [continuing]. Occurs as the behavioral offset would have been intended to correct, so if you don't assume that the behavior occurs, then there would be a large difference in those projections.

Ms. WILENSKY. Absolutely.

Chairman STARK. Thank you.

Mr. MOODY. Mr. Cardin.

Mr. CARDIN. I have no questions.

Mr. MOODY. Dr. Wilensky, just one brief follow on that. If we adjust the price to anticipate the behavioral offset, a behavioral response, to keep the budgets in line aren't we confronting the doctors with an additional incentive for more volume changes?

Do you see what I am saying? It is a sort of chasing your own tail kind of problem.

Ms. WILENSKY. And assume that will you do it more?

Mr. MOODY. In other words, you confront——

Ms. WILENSKY. It is certainly possible that, to the extent that either as a result of anger and frustration, or as a result of economic pressures, or as a result of whatever it is that affects either the

physician or the patient, because the patient will be facing lower out-of-pocket expenses, that it could well be that there is more change than what we anticipated.

Mr. MOODY. So there are the corrective measures themselves, that will stimulate——

Ms. WILENSKY. It could happen. I just want to point out that in 1990, when we didn't have the sense that we were pushing anybody to do anything, we had an assumed change of 50 percent in terms of the savings that had been enacted in the previous year in law. We still underestimated the change in exenditures by 1½ percent. It is not like we haven't had recent experience to suggest not only is the 50-percent behavior change something we have observed, but that it doesn't capture enough of what happens.

Mr. MOODY. Dr. Nelson, any comments on that point?

Dr. NELSON. Just as I said, there are so many other factors that impact the volume of services, including what benefit increases are——

Ms. WILENSKY. Absolutely.

Dr. NELSON. I think the more things are paid for by Medicare, and they are things that patients want and need, the more of them will be done.

Ms. WILENSKY. And, as I have tried to make clear, this is not done to impugn the motives of physicians. It is trying actuarily to estimate where expenditures will result. If it is the patients demanding more services because they have more protection against balanced billing, that has no differential effect on the total expenditure estimate than if it is a physician that is unbundling or upcoding or all those other activities that we are already seeing advertised as how reimbursements can be maximized.

It is, unfortunately, something that we know occurs some of the time. But it is not just physicians who can change behavior. It is certainly the patients as well.

Mr. MOODY. OK. Thank you.

Mrs. JOHNSON. May I ask a question?

Mr. MOODY. Yes, certainly.

Mrs. JOHNSON. Thank you. I would like to ask one last question, because I forgot to address it specifically in my time. How does HCFA plan to respond to PhysPRC's recommendation that OBRA 1990 be modified to restore separate payment for EKGs?

We have had some general discussion of that. I would just like to nail it down, because that has become such a very serious issue.

Ms. WILENSKY. Well, I think there are two different issues, one that is related to EKG interpretations where a visit occurs, and one that relates to the interpretation when there is no visit, either because it is referred to a specialist or because it occurs on an outpatient visit.

I believe there is a problem in the second category; that is, when there is no visit attached to the interpretation. We have no way of paying for the interpretation. It will cost, unless there is some other adjustment done, $500 or $600 million to make that correction, although PPRC has at least discussed some options that could be looked at in terms of paying differently for doing the EKG itself.

With regard to bundling the interpretation into the visit, we believe that is an appropriate thing to do. What we have done is to

spread the EKG interpretation charge, as measured by the relative value, into the different levels of visits according to the frequency with which they actually occur. That is, we looked at where EKGs are provided in terms of the kind of visit, and distributed an amount for the EKG interpretation.

It is exactly what we do for laboratory tests. That is, we know that some physicians do a lot of laboratory tests, routine tests, and some do very few. We provide, in the visit amount, an amount for laboratory tests that includes an interpretation. We believe that is a reasonable activity.

We do think there is a problem with regard to the EKGs where there is no visit. There is a budget problem about how you take care of it at the moment. And at the moment, we are by statute not allowed to pay for the interpretation charge.

Mrs. JOHNSON. I appreciate the differentiation you are making between those associated with a visit and those not associated with a visit, but I think even in the former category, where they are associated with a visit, that the EKG distribution is not equal throughout the physician population, and therefore many are going to be reimbursed for something they don't do, and those who take the responsibility for reading it, and that responsibility in the structure of our medical profession is a significant responsibility for which you are liable, get nothing extra.

My sense from my mail is that primary care physicians are going to be the hardest hit by this provision.

Ms. WILENSKY. I don't think that is true. The people who will be hardest hit are the cardiologists, and it is actually primary care physicians who may well be assisted by this.

I would like to point out that it is how we handle the interpretation of laboratory tests of a routine nature. That is, we bundle them into the visit charges.

Mrs. JOHNSON. I understand that logic, but that logic isn't without some merit. I do think that this raises some other questions, and I am concerned about what I am hearing from the real world out there.

And PhysPRC, you are recommending reconsidering the office visit changes as well as those readings done outside of an office visit or not connected to an office visit?

Dr. EISENBERG. That is right. We believe that if the savings that Dr. Wilensky has referred to need to be maintained, there are ways in which that could be handled, for example, by a more rapid reduction in electrocardiogram payments from the current payments; that is, moving towards the RBRVS fee more quickly than we would otherwise.

And there are other remedies, but we think that the bottom line is just what you said, that there ought to be a payment for the electrocardiogram for those physicians who do it. We know the amount of work that it takes based upon the RBRVS, and it would be relatively easy to pay an appropriate amount for it.

Mrs. JOHNSON. Thank you. I hope to continue discussion of this matter.

Dr. EISENBERG. May I comment on a previous question you had asked?

Mrs. JOHNSON. Yes.

Dr. EISENBERG. It had to do with coding for visits. We agree with the people with whom you have spoken that there are great concerns about the clarity and complexity of the visit codes, and we, like those who have written to you, are concerned about the difficulty that physicians may have in moving to new visit codes. Therefore, we have worked hard with the AMA, with the CPT committee, and with HCFA to try to develop new visit codes that would be less complex and would give a clearer message to physicians about exactly what we mean when you do a certain type of a visit.

We are concerned that the proposed visit codes still remain too complex. It is more than just the changes that have taken place in the past couple of years which HCFA is addressing by trying to reduce the hassle factor. But it also has to do with the clarity with which the codes are described for the future. So we would like to continue to work on clarifying those.

Mrs. JOHNSON. I do appreciate that, and I truly commend Dr. Wilensky for getting together this paperwork hassle group and giving us a forum in which we can begin to address those issues with the people on the front lines. I look forward to working with both of you on those issues.

Thank you.

Mr. MCDERMOTT [presiding]. Further questions from the committee? Mr. McGrath. Mr. Cardin.

[No response.]

Mr. MCDERMOTT. Thank you. Senator Moynihan once said, when asked a question about a particular issue, "If there is a simple answer to this, we would have already done it. What we need in this case is a great complexifier." [Laughter.]

It hardly seems necessary to talk about complexifiers, and I would like to congratulate all the groups who have stayed at the table to discuss this issue. If you want to turn a complex issue over to us and let us fix it, you do it at your own risk. So I would encourage you, as the chairman did, to keep working until we get to January 1992 to get this thing right.

Thank you all.

Mrs. JOHNSON. That is how we got here in the first place.

Mr. MCDERMOTT. That is right.

The next panel will be Dr. Graham, representing the American Academy of Family Physicians; Dr. Cleaveland, representing the American College of Physicians, who is accompanied by Mr. Shapiro; and Dr. Gerald Austen of the American College of Surgeons.

We want to welcome you all to the committee.

We want to welcome you to summarize your testimony in the order in which you were introduced. Your entire statement will be placed in the record.

If you will start, Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Mr. Chairman, my name is Bob Graham. I am the executive vice president of the——

Mr. MCDERMOTT. Let me just ask you to suspend for just a minute.

Will those people in the room over by the paper please stop talking so we can begin the testimony?

Dr. Graham.

Dr. GRAHAM. Thank you again, Mr. Chairman. I am pleased to represent the views of the academy, some 70,000 family physicians. Given the substantial amount of testimony which the subcommittee has already heard, I will try to summarize more in terms of our primary policy concerns rather than going into specific detail, which, as you have noted, is included in the prepared text.

I think perhaps the starting point for the discussions this morning should be what the intent of the legislation was as we worked with the committee in 1988 and 1989. That intent, as my memory recalls, was: first, to provide more explicit incentives for evaluation and management services and physicians providing those services, recognizing that an imbalance of physician payment needed to be redressed; second, that in the transition of going from one payment system to another payment system there should be a budget-neutral transition—in other words, a fixed pie should be redivided by new rules; and, third, a recognition that the reason for doing this on the part of the Congress was to eventually deflect the curve of overall growth in physician payments and to do that year by year, reflecting on what actual experience was.

We believe that the law as passed—and, indeed, major sections of the regulation proposed by HCFA—take important steps and positive steps in this direction. But we have some very specific concerns.

Number one, we believe that the proposed mechanism and magnitude of the behavioral offset is without substantial foundation. Philosophically, we do not believe that practitioners should be penalized in reimbursement for services provided based upon speculation as to what future behavior may be.

Second, the nature of the statute is such that if any behavioral offset is to be proposed, even under a compromise, we have a problem with what is essentially a tripling phenomenon, which has been explained by the prior witnesses. So that the full impact of whatever the offset would have been is tripled in the first year.

The third problem with the behavioral offset is a disjunction of logic. If, indeed, there is to be an offset that is factored into the conversion factor because some physicians facing reduced fees will increase services, we don't think it makes any sense to apply that offset to the conversion factor, which, in 1992, primarily affects physicians providing evaluation and management services whose fees were supposed to go up. So the behavioral offset in all of its complexity and for all of the reasons that you have heard before is problem number one that we see.

The second problem is the structure of the transition. I thought Dr. Wilensky's explanation to you of the reasons for asymmetry was exceptionally clear, and, indeed, one of the reasons for asymmetry was put in there to help physicians such as family physicians in the transition to come up to scale more rapidly than might otherwise have been the case. The problem again is the triplicate multiplication in the first year that is required in adjusting the conversion factor. So the transition structure continues to give us

some problems. Indeed, those are addressed in the statement, and our specific solutions are offered to you.

The policy impact that I would like to dwell on has been touched on by the earlier panel. What were we trying to accomplish? What was the Congress trying to accomplish? Why did the academy support this legislation? We believe that there is a substantial undersupply of generalist physicians—the types of physicians who are critically important to providing access to Medicare beneficiaries, the types of physicians as that beneficiary population grows in the next 10 to 20 years we must have more of. At the present time, we are struggling to encourage medical students to select careers in family practice, general internal medicine, and general pediatrics—pediatrics being less of a concern for the Medicare beneficiaries.

But we recognize that the incentive system has to be changed if we are to be able to make a cogent case for those individuals in terms of their practice in the next 10 to 20 to 30 years. We have substantial concerns that the first steps toward implementation proposed in the regulation markedly degrade our opportunity to do that.

Our advice and our request to the committee as we come before you is we believe the behavioral offset does need to be addressed. Our preference would be no behavioral offset; don't bet on the future. If in the spirit of compromise some adjustment is made in the behavioral offset, the tripling phenomenon must be removed. You need to be able to spread that across all fees. Similarly, in the transition formula, which may well take legislative action on the part of this committee and the Congress, the major step that needs to be taken is to remove the tripling effect that is included in the first year.

With that, sir, I will hold the rest of my further comments and refer for technical discussion to the full statement. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF ROBERT GRAHAM, M.D., AMERICAN ACADEMY OF FAMILY PHYSICIANS

Good morning, Mr. Chairman and Members of the Subcommittee.

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians. Our 70,000 members provide vital primary care services to Medicare patients across the nation, and serve especially in rural communities where access to health care is never taken for granted. We appreciate the opportunity to comment on the recently published notice of proposed rulemaking (NPRM) implementing the Medicare fee schedule.

We also very much appreciate your leadership in enacting Medicare physician payment reform. This Committee has been a driving force for payment reform -- establishing the Physician Payment Review Commission (PPRC), commissioning the Harvard relative value study, and most recently, providing the leadership that brought about enactment of the RBRVS. Like family physicians, you have a very real stake in seeing the public policy underlying Medicare physician payment reform come to pass.

Unfortunately, the recently published NPRM threatens the underlying public policy purpose of Medicare physician payment reform. The Academy continues to review in detail the technical policies contained in the NPRM and will comment formally on other aspects affecting family medicine. For today, we will confine our testimony to four issues of major concern with the Secretary's proposal.

Budget Neutral Conversion Factor

As you well know, the new Medicare fee schedule was to have been implemented in a budget neutral manner, with excess payments for overpriced services redistributed to underpriced services. Instead, the NPRM calls for a cut in the conversion factor of 16 percentage points. These reductions are triple what they would otherwise be due to the so-called leveraging effect of the transition. According to the NPRM, all adjustments to physician payments necessary to produce budget neutrality are applied to the fee schedule's conversion factor in 1992. However, since only one third of physician payments reach the fee schedule in that year, all adjustments must be tripled.

The Health Care Financing Administration (HCFA) acknowledges these budget neutrality adjustments will, in fact, reduce Medicare's payments to physicians by $3 billion in 1996 and $8 billion over the course of the five-year transition.[1] Instead of a budget neutral redistribution of Medicare dollars from overpriced procedures to underpriced services, primary care payments will remain low, payments for other services will be reduced far more than anticipated, and much of the savings will be reserved for deficit reduction. AAFP finds it unconscionable that budget neutral payment reform could be parlayed into the largest Medicare budget cut in history.

This enormous budget reduction is not only unfair and contrary to Congressional intent, it threatens the very purpose of payment reform. According to the NPRM, family physicians can expect to realize only half of the anticipated 30 percent increase in Medicare fees. Payment for our most frequently provided service, office visits, will increase only a few dollars. Given the very low base from which so many primary care and rural physicians begin this process, every penny of promised payment reform is crucial. The nominal payment increases outlined in the NPRM make it highly unlikely that hoped-for incentives for physicians to choose primary care as a specialty and/or to locate their practice in a rural community will be effective.

Furthermore, it appears that family physicians will bear the brunt of the 16 percent reduction in the conversion factor during the transition. Ironically, although the transition to the fee schedule was intended to maximize gains for underpaid services in the first year, it will have the effect of minimizing such gains. Most family physician fees move to the RBRVS in 1992. Therefore it is predominantly family physicians who will feel the full weight of the 16 percent reduction in the conversion factor immediately and fully throughout the transition. By contrast, most other physician fees will be paid on the historical payment basis in 1992, and only blended with the fee schedule from 1993 to 1996.

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[1] In fact, the magnitude of the budget cut is much larger. Two thirds of the reduction in the conversion factor is due to a behavioral offset, yet HCFA does not count this considerable payment reduction as producing budget savings.

AAFP urges Congress to pass legislation remedying this serious situation. We believe any budget neutrality adjustments in 1992 should be applied to all physician payments, not just to those based on the RBRVS conversion factor. This change would improve payments in two ways. First, it would eliminate the "leveraging" which effectively triples the size of any budget neutrality adjustments. Second, it would reduce the disproportionate impact of budget neutrality adjustments on primary care services that move immediately to the fee schedule.

Behavioral Offset

Most of the 16 percentage point reduction in the conversion factor is due to the so-called behavioral offset. In order to recoup spending for anticipated behavioral responses to declining fees HCFA proposes to prospectively reduce 1992 payments by 3.5 percent. This will be leveraged to a 10.5 percent reduction. AAFP vigorously opposes the application of a behavioral offset to physician payments for several reasons.

First, Congress has already enacted a program to moderate growth in spending for physician services, the Medicare Volume Performance Standards. HCFA says MVPS is inadequate for responding to inappropriate volume growth because default formulas in the law limit the penalty that HCFA can apply to physicians, in the absence of legislation. We believe Congress wisely limited HCFA's discretion to implement significant fee cuts on its own. The Administration's proposed behavioral offset illustrates how such unbridled discretion would likely be used.

However, Congress placed no limits on legislative responses to inappropriate volume growth. Further, Congress called for a gradual transition to payment reform so that there would be ample opportunity to observe and correct any problems that might arise. The behavioral offset proposed by HCFA is entirely inappropriate and should be prohibited.

Second, HCFA's application of the behavioral offset is illogical and unfair, on its face. The reduction is intended to offset spending caused by anticipated behavior from physicians whose fees are declining in 1992. Yet, the offsetting cut is applied to physician fees that are increasing in that year -- those of rural and primary care physicians. This misapplication of the offset serves only to minimize sorely needed payment increases for these physicians.

Finally, HCFA's proposed behavioral offset simply is not supported by existing research on physician payments. The assumptions about volume responses are guesses, at best, and appear to assume the worst about doctors and the Medicare program. Further, HCFA's assumptions appear to disregard the transition's leveraging effect, which converts this one-year offset into a permanent and severe downward rebasing of physician payments.

For these reasons, the Academy urges the Congress to prohibit application of a behavioral offset to the conversion factor.

Geographic Adjustments

We have testified previously to this Committee on geographic adjustments for Medicare physician payments. We must reiterate our very strong objection to the proposed geographic adjustment factors. The GAF will result in Medicare fees that vary by as much as 30 percent between lowest paid rural areas and the highest paid urban areas. Such discrepancies in payment will certainly perpetuate the shortage of physicians in rural areas.

Our primary objection to the GAF is that it is flawed conceptually. A full accounting of physician practice costs would attempt to reflect the opportunity costs of practice location choices. Physicians obviously base such decisions on far more factors than the cost of practice. Experience in this country and in the rest of the developed world clearly indicates that in order to induce physicians to locate in underserved areas, they must be paid more, not less than if they locate in areas already served by an abundance of physicians.

While the AAFP opposes the imposition of any GAF, we would urge, at a minimum, that immediate steps be taken to make the proposed GAF more accurate and equitable. First, we recommend that a study be undertaken to validate the accuracy of the GAF before it is implemented. A validation study was already mandated in OBRA 1990, though study results are not mandated before July 1992. The index proposed in the NPRM relies on proxy measures of medical practice costs. Surveys of actual practice costs, however, show that rural practice costs are equal to, or even exceed, those in urban areas.

Second, we believe that HCFA's proposed GAF will systematically and inequitably under-reimburse family physicians for practice expenses. Of all specialties, family physicians have the highest practice costs as a proportion of gross practice revenue. This is due in part to the fact that we provide a much wider range of health care services for our patients and because we locate disproportionately in rural areas where economies of scale are much more difficult to achieve. According to the statute, the practice expense relative values reflect a weighted average of the practice-expense-to-gross practice-income ratio of all specialties providing a given service. Because of the class of services that we provide, virtually every service provided by family doctors is also provided by other specialties, all of which have lower practice expenses. The averaging used to calculate the practice expense relative values, therefore, always results in a practice expense relative value that is reduced relative to family physicians' actual practice expense proportion. HCFA's practice expense GPCI tends to further reduce the practice expense relative value for family physicians, simply because they are more likely to be located in rural areas. We think this inequitable.

Section 1848(e)(1)(B) authorizes the Secretary to establish class-specific geographic cost of practice indices when the application of the general practice expense index would be substantially inequitable. We urge the Committee to change this permissive language to a requirement that separate adjustments be applied to reverse this systematic under-payment of rural physicians.

Third, the Academy urges Congress to adopt recommendations by the PPRC concerning consolidation of geographic payment areas. PPRC recommends the 240 current carrier areas be replaced with statewide fee schedule payment areas except in states with high intrastate price variation. Under this policy, the number of statewide fee schedule areas would increase from 14 to 34, and the total number of payment areas would decrease from 236 to 94. AAFP recognizes the administrative difficulties of implementing payment areas changes simultaneously with pricing and coding changes. We hope carrier areas can be consolidated as early as 1993.

Payment for Direct and Indirect Practice Costs

The Academy urges Congress to adopt another PPRC proposal relating to direct and indirect practice costs. PPRC would divide practice costs into direct and indirect components and pay the direct portion only when the physician actually absorbs the direct cost of providing the service. Direct costs are the nonphysician employee time, supplies, and equipment that are actually consumed in providing a service. Indirect costs are the overhead expenses such as maintaining an office and administrative staff that accrue to all services regardless of where they are delivered. For example, while the direct cost of providing an inpatient surgical procedure is borne largely by the hospital, the NPRM would include a full portion for practice costs in the surgical fee. The NPRM does propose to limit payment for practice expense for a list of specific services which Medicare currently covers in ambulatory surgery centers (ASCs).

AAFP urges the Congress to replace the current method of estimating practice expense relative values with a resource-based method that distinguishes between direct and indirect costs incurred by physicians when a service is provided in different settings. Such a resource-based method should incorporate alternative equipment-use volume assumptions that do not compromise access to care in rural areas.

Budgetary Considerations

The Academy understands that budget scoring rules adopted under the 1990 budget summit agreement significantly complicate Congressional consideration of some of the legislative remedies we have proposed. We are sympathetic to the need for deficit reduction, as well as the need to control health care costs in general. In the past, we have worked closely with this Committee and others in Congress on both of these economic concerns. For example, AAFP supported enactment of the MVPS program to address the rising cost of medical services. We pledge our future, continued efforts to control the cost and volume of services in ways that are fair and appropriate.

At the same time, we must state strongly our conviction that the budget cuts inadvertently produced by the transition to RBRVS must not be permitted to occur. Further, OMB scoring rules should not be applied in such a way that the bill for righting this unanticipated wrong is handed to physicians, taxpayers or Medicare beneficiaries. We ask simply that the promised budget neutral transition to fee reform be delivered.

Conclusion

Mr. Chairman, when we started on the road to Medicare physician payment reform, we had great hopes. A national system of resource-based payment for physician services held the potential to neutralize perverse financial incentives contributing to a host of serious problems:

* the overprovision of expensive medical procedures coupled with an under-reliance on cost effective primary care;

* the maldistribution of physicians between urban areas and underserved rural areas; and

* the propensity of medical graduates to select careers in procedure-oriented specialties over primary care medicine.

We never believed that the Medicare RBRVS, alone, would solve these problems, But it was a tremendous first step, and one, we hoped, that signalled Congress' willingness to pursue solutions to these problems throughout our health care system.

The promise of Medicare physician payment reform is still the goal of family physicians. We cannot overstate the need for that promise to be kept. Legislative action is needed, both to make the law work as intended, and to prevent the Administration's preemptive strike on the Medicare budget.

The behavioral response to payment reform Congress should fear most is perpetuation of the status quo. If payment methods continue to encourage physicians to make specialty choice and practice location decisions that discourage access to primary care, our nation's health care problems will only grow worse.

Mr. McDermott. Dr. Cleaveland.

STATEMENT OF CLIFF R. CLEAVELAND, M.D., CHAIRMAN, HEALTH AND PUBLIC POLICY COMMITTEE, AND MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF PHYSICIANS, ACCOMPANIED BY HOWARD B. SHAPIRO, PH.D., ACTING DIRECTOR OF PUBLIC POLICY

Dr. Cleaveland. Mr. Chairman, the American College of Physicians appreciates this opportunity to present the views of 70,000 internists and subspecialists in internal medicine whom we represent on the crucial issue of physician payment reform. I am Cliff Cleaveland. I am a full-time practitioner of internal medicine in Chattanooga, Tenn., and with me is Howard Shapiro, acting director of public policy for the college.

Most of the points which we wish to emphasize have already been touched upon, and I would like to comment on the personal impact of the proposed legislation on a practitioner.

The incentive system is very much tied into physician morale, and morale in the community of general internist, of family physicians, of primary providers of health care is at a very low, sad point at this time. From the very outset, internists and family physicians have been committed to the full and fair implementation of payment reform. We thought that this would be our moment of recognition that what we did truly had value in the eyes of the payers. Instead, we see now that the promised gains may be simply nullified in a budget-cutting exercise.

In my practice, where we accept assignments, we run a 60-percent overhead. And as I try to cross-walk from the old payment system to the new system of charges, I find that one of my most frequent charges, which would be a 15-minute evaluation of a patient in my office, for which now I receive $25.20, would rise to $27 with implementation of the fee schedule. This would be opposed to $31.50 if I were not being punished for an anticipation of offenses in increasing my volume.

My colleagues and I who see Medicare patients can't very well increase our volume. We are working extremely hard right now. I see an average of 30 patients per day. Half of my patients are Medicare patients, and are patients who require intense effort and thought a lot of time because they have multiple illnesses. The same individual may have diabetes and hypertension and Parkinsonism. Medicare patients require our best care, and they will continue to get our best care. We are committed to what we do.

The problem, as alluded to, is what about the next generation of caregivers. Medical students are not selecting careers in internal medicine. In the current year, only 57 percent of first-year internal medicine residency slots were filled by graduates of U.S. medical schools. Our numbers have gone down for 5 consecutive years, and a similar experience is reported by family practice and by pediatrics. This, again, gets to the tie-in of morale and incentive.

The question then is not of access this year or next year. Of course, we are going to continue to look after our patients. I am not going to dump my patients, many of whom are my friends. It has to do with access, though, in 5 years and 10 years when I am

tired and I want to retire, and I want to take on an associate who will enjoy a career in general internal medicine as much as I do.

So what we would ask is that all parties to the regulation come together without rancor and sit down and negotiate the threatened offsets that are based on behavior, which I think is really somewhat of an insult to people who practice. This is rather like a parent who spanks their child before they go to school knowing that they are going to misbehave some time during that day. I don't think we are going to do that.

I thank you very much for this opportunity to testify before the committee.

[The prepared statement follows:]

STATEMENT OF THE
AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE

June 25, 1991

THE RBRVS-BASED MEDICARE FEE SCHEDULE

The American College of Physicians appreciates this opportunity to present the views of internists and subspecialists in internal medicine on the critical question of physician payment reform. I am Dr. Cliff Cleaveland, an internist in private practice in Chattanooga. I am a Regent of the College and Chairman of its Health and Public Policy Committee. Accompanying me is Howard B. Shapiro, PhD, Acting Director of Public Policy.

Mr. Chairman, we've got to work together - all of us - HCFA, the Congress, and the physician community - to make the Medicare Fee Schedule work. We have come too far to let it slip from our grasp at the point of implementation. Enactment of RBRVS was the result of collaborative work, which the College continuously supported, over a period of several years. We all cooperated and compromised in 1989 to achieve a balanced package of reforms. The College and, we think, all of the medical community, remains committed to the full and fair implementation of that legislation. We want to work with you and with HCFA to realize its promise.

In most areas, HCFA has done a good job in developing a complex regulation, with the able support of Dr. Hsiao and his team at Harvard and of the Physician Payment Review Commission, under the strong guidance of Dr. Lee and Dr. Ginsburg. We congratulate Dr. Wilensky and her staff. With the exception of three issues, albeit critical ones, addressed in our statement today, our differences with the proposals in the regulation are relatively small. We will respond to HCFA on those issues during the comment period.

What we find in examining the proposed regulation is that the Resource-based Relative Value Scale (RBRVS) narrowly defined - that is, as a relative re-valuation of physician work - operated as we expected it to. That is, undervalued evaluation and management (E/M) services rise in relative value, overvalued procedures fall, and the wide geographic variation tied to historical charges is flattened out.

What is so frustrating to our members is to see many of these gains essentially wiped out by budget-related calculations and interpretations of the legislation. HCFA estimates that the fee schedule, as proposed, will result in a zero gain for internal medicine in 1992, and a cut of 3% in payments per service by 1996. Our members are angry that what had been promised as a long-awaited recognition of the value of their services as thoughtful clinicians who spend time with their patients, looks like it will turn out to be little more than a budget-cutting exercise.

Make no mistake that this will produce a cynicism that will have very real, deleterious effects on the Medicare program over time. Medicare may begin to look more like Medicaid in the eyes of the practitioner - a third-rate program that provides inadequate care for the population it is supposed to serve.

Mr. Chairman, we are not questioning anyone's motives, or blaming anyone. We believe that all parties are disturbed that the gains of RBRVS are negated by the calculations of the conversion factor. Accordingly, we need to sit down together and craft a solution, be it legislative, regulatory, or a combination of both. The remainder of our statement outlines those areas which need to be fixed.

The Asymmetrical Transition

Congress explicitly recognized the need for primary care services to reap the benefits of RBRVS reform promptly. Thus, you decided to move primary care services towards the full fee schedule amount quickly, and created a transition rule to do so. The same provision also has the effect of cushioning the reduction in payments to services above the fee schedule amounts. The effect is a net cost in 1992, although no net cost across the full transition period.

We do not believe that the benefits which Congress intended to give primary care with the transition provision, it intended to take away with the requirement for budget neutrality in 1992. We urge the Committee to state its intent to HCFA that the transition language be allowed to have its intended effect. Absent a change in HCFA's implementation of budget neutrality, we urge the Committee to amend the law to mandate that the budget neutrality calculation not include the projected net cost of the transition provision.

We believe that this change is essential to achieve one of the central goals of payment reform: setting appropriate payments for evaluation and management services. The change would restore a 2% cut in fees or, with the tripling utilized by HCFA, it would restore a 6% cut in the conversion factor.

The Tripling Effect of the Conversion Factor

It is not at all clear to us that the law requires that budget neutrality adjustments be applied to the conversion factor alone. There is no explicit direction to do so, and only an interpretation of ambiguous language in section 1848(d)(1)(B) can be used to justify this approach. Because RBRVS amounts apply only to about a third of total payments in 1992, HCFA's interpretation requires a tripling of any adjustments for budget neutrality when calculating the conversion factor. Thus HCFA's proposed 2% adjustment for the asymmetrical transition and 3.3% adjustment for projected increases in volume (more about that later!) become, respectively, 6% and 10.5% cuts, for a whopping 16.5% cut in the conversion factor.

It makes sense to us that any adjustments for budget neutrality be made across both components of the physician fee in 1992 - the RBRVS fee schedule component and the historical charge component. This would spread the correction equitably across all fees and all physicians. Budget neutrality is a comparison of total payments in 1991 under historical charges to total payments under a blended system. To make a correction for any difference utilizing the smaller component of the blended payment has little logic to it. We will urge HCFA to eliminate the tripling effect by correcting for budget neutrality across the total payment. Again, we hope that Congress will take this position with HCFA and, if necessary, amend the law.

Behavioral Offset

Physicians, as everyone else, respond to financial incentives. Indeed, the premise of the RBRVS is that setting appropriate payment levels will lead to a more balanced practice of medicine, augmenting primary care and resulting in more appropriate care and fewer unnecessary services. This embodies the clear benefit of the RBRVS to patients. We wanted to pay the physician for time spent with patients in the hope that physicians would do just that. Conversely, we did not want to drive physicians to overutilize procedures because the time and resources used for those procedures were disproportionately compensated.

We have four objections to the way in which HCFA proposes to reduce fees to take into account anticipated increases in volume under the fee schedule - the so-called behavioral offset. First, as pointed out by PPRC in its 1991 Annual Report, there are no conclusive studies that show a relationship between fee cuts and volume increases. In fact, we were struck by 1984-88 data presented by PPRC in its recent report to Congress on the Medicare Volume Perfomance Standard and fee update. The data showed that during that period of

Medicare fee freezes and reductions, growth in volume remained essentially flat.

Second, we strongly object to HCFA's refusal to anticipate possible *reductions* in volume in response to increases in fees. Both PPRC and the Congressional Budget Office adjust their calculations on this side of the equation, so that the net offset they endorse is more modest. HCFA should do the same.

In this regard, we would note that never before have changes of the complexity of the Medicare fee schedule been undertaken. Thus, even the stronger studies have to be in part discounted. Not only do you have fee increases at the same time you have reductions - and, of course, both shifts occurring in most practices - you also have major changes in coding of services, balance billing, beneficiary out-of-pocket costs, and so on. All of this prompts us to question seriously the very conservative assumptions that HCFA used in its calculation of the behavioral offset.

Third, we object to an approach which lumps all physicians together and penalizes all regardless of their record of utilization of services. (For the same reason, we objected to the MVPS.) In this regard, many have suggested that physicians will in particular increase evaluation and management services, because it is easy to schedule a patient for additional visits. But it is the E/M services which would receive increases under the RBRVS, so the incentive to offset cuts is not operative. Also, data from PPRC show the volume of these services to have increased very little over the last number of years.

Finally, we have to ask how much of the volume problem stems not from an increase in services, but an increase in billings that occurs from disaggregating elements of care and billing for each item separatey. This practice of so-called unbundling should be investigated by HCFA and plans laid to stop this gaming of the system.

Given inconclusive support for the theory of the behavioral offset, particularly in light of the complex changes initiated by the fee schedule, we will oppose any fee reduction to correct for anticipated changes in utilization. We urge the Committee to take the same position. If there is a behavioral offset, it should be no greater than the 1% offset recommended by the PPRC.

Other Issues: EKGs, Practice Costs, Coding Reform

We will mention briefly three other issues of substantial concern. We continue to object strongly to the mandated elimination of payment for a unique professional service - the physician's interpretation of an EKG. The statement implied in doing so - that Congress does not value this skill - remains deeply troubling to physicians in and of itself, and as a precedent for other services.

We believe that Congress should repeal this provision of the 1990 Reconciliation Act. In the proposed regulation, HCFA has made a small adjustment to all visit fees, but this is inadequate and spread far too thinly across all visits. We will propose some narrowing of the visit categories that should be adjusted for EKG interpretation. But the correct solution is to recognize interpretation as a separate service with its own relative value, as is supported by the Harvard research.

The treatment of practice costs is an anachronism in the payment reform legislation. Rather than measuring resources used, consistent with the RBRVS, practice costs are tied to historical charges. The PPRC has done excellent work in this area, and proposed a direct accounting of practice costs by site of service. Further work remains to be done to develop the data, but we urge Congress to amend the law at the first opportunity to mandate a resource-based approach to measuring practice costs.

Coding reform is a major element of implementing the fee schedule for E/M services. We have supported the use of new codes that would take into account the content of services, complexity of the case, and the typical time involved. Both PPRC and AMA's CPT Editorial Panel have contributed significantly to development of a new system that HCFA appears prepared to accept, but has not yet endorsed. We have some concerns about how

HCFA will crosswalk from old codes to new codes - an important issue - and we will address those in our regulatory response.

Conclusion

Mr. Chairman, we would prefer a regulatory solution to these problems. Perhaps with the help of Congress in clarifying the intent of the law, we can convince HCFA and the Administration to revise the proposed regulations as necessary.

We recognize that there is no great desire to legislate on this or other elements of Medicare this year, and it is unlikely that there will be a reconciliation bill. We also recognize that if the Committee attempts to make some of these changes, it runs into the straightjacket of the pay-as-you-go provisions of the 1990 budget agreement.

Nonetheless, we all have a stake in the success of the RBRVS. The College believes that the entire payment reform package enacted in 1989 can promote fundamental changes in the practice of medicine in very desirable ways. It is not hyperbole to say that the importance of RBRVS reform goes well beyond Medicare and will play a central role in any significant improvement in our health care system. Given that premise, it is incumbent on all of us to find solutions to the problems we have outlined. We are willing to work with this Subcommittee to identify those solutions.

The point is, if we all give first priority to the realization of the promise of RBRVS in 1992, then we can work together to remove obstacles to crafting the solutions that we need. The American College of Physicians is committed to doing so.

Mr. Chairman, thank you for holding this hearing and considering our views.

Mr. McDermott. Thank you.
Dr. Austen.

STATEMENT OF W. GERALD AUSTEN, M.D., F.A.C.S., CHAIRMAN, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS

Dr. Austen. The American College of Surgeons believes it is essential that the relative values that will be used for Medicare payment purposes beginning in January 1992 be as accurate as possible. In our judgment, this will require a great deal more effort between now and January 1. We believe that there is considerable evidence that the relative values that are proposed by HCFA for many surgical procedures are flawed.

For example, some vignettes that were used to collect estimates of time and intensity for surgical services reflected an amount of work at the low end of the range rather than the average amount of work. Some vignettes described the typical patient, not the typical Medicare patient. The amount of care that is required by the average Medicare patient for many surgical procedures will be significantly greater than the physician's time and effort that are required by the average younger, non-Medicare patient.

To the extent that the process for setting relative values does not reflect fully the resource inputs that are associated with the care of Medicare patients, the premise upon which the entire system is theoretically based is violated.

In addition, the college is concerned about the double standard that applies to many physician services under the proposed fee schedule. The services of assistants at surgery, for example, would be paid for in a manner that is not based on a resource-based system. Similarly, the services that are provided by newly practicing physicians would be paid at lower amounts than other physicians, even though there is no evidence that the resource inputs for newly practicing physicians are different from those of other physicians.

The college also is bothered by the double standard that relates to preoperative services. Special documentation will be required by surgeons who stabilize patients prior to operation in order to receive payment for these services. Such documentation would not be required if these same services are provided by someone other than a surgeon.

The resource-based relative values developed in the Harvard project did not include preoperative visits within 30 days of operation. Yet HCFA proposes to include these visits as part of the global surgical fee in spite of the fact that HCFA has not included any resource inputs for these services. Similarly, we are not satisfied that full credit has been given to all the postoperative visit services that would be included in the definition of global surgical services.

The American College of Surgeons wishes to add its strong opposition to the behavioral offset that is proposed by HCFA. Among other things, HCFA has not given sufficient information to judge the reasonableness of the conversion factor before any offsets. Many changes in payment policies are proposed that would reduce

Medicare payments below what they would be absent the fee schedule.

As the original supporters of the Medicare volume performance standards concept, the college believes that the MVPSs provide a new method of addressing concerns about volume and intensity. Moreover, HCFA has several other tools now in place, such as utilization and peer review and physician profiling by carriers, to guard against medically unnecessary care. We strongly believe there is inadequate evidence to justify the proposed behavioral offset.

We also wish to remind the subcommittee that many surgical services already have experienced substantial payment reductions under past budget reconciliation acts. HCFA's fee schedule impact analysis overlooks all of these past reductions and then projects additional reductions of as much as 35 percent.

A preliminary analysis shows that some of the proposed Medicare fee schedule amounts that were published on June 5, 1991, are lower than Medicaid payments that were made in 1989 for the same services in many locales. We believe these comparisons strongly suggest that Medicare physician payment reform is producing unreasonable payment reductions. These reductions are far in excess of those originally contemplated by the Congress and are in addition to those already mandated under previous legislation.

Thank you.

[The prepared statement follows:]

STATEMENT

OF THE

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

W. Gerald Austen, MD, FACS

RE: Medicare Payments to Physicians Under The Resource-Based Relative Value Scale

June 25, 1991

Mr. Chairman and Members of the Subcommittee, I am W. Gerald Austen, MD, FACS. I am the Chairman of the American College of Surgeons' Board of Regents. On behalf of the more than 51,000 Fellows of the College, I appreciate this opportunity to provide the College's preliminary views with regard to the proposed regulations to implement the Medicare physician payment reform plan that was enacted in 1989.

As you know, the College has been supportive of a major element of the payment reform plan; specifically, the Medicare volume performance standards (MVPS), including a separate MVPS for surgical services. On the other hand, the College has had longstanding reservations about the methodology that was used in the Harvard project to determine the relative value of physicians' services. Our concern is that the methodology ignores several factors that are considered to be almost universally important in determining the value of goods and services in this country. In particular, the methodology ignores the value of services to the patient. With this background, I would like to offer the following comments about various aspects of the proposed regulations that were published on June 5, 1991 by the Health Care Financing Administration (HCFA).

Resource-Based Relative Values

Despite our reservations about the use of resource inputs as the sole determinant of the relative value of physicians' services, we believe it is essential that the relative values that will be used for Medicare payment purposes beginning in January 1992 are as accurate as possible. In our judgment, this will require a great deal more effort between now and January 1. We believe there is considerable evidence that the relative values that are presently proposed by HCFA for many surgical services are flawed.

With respect to thoracic surgery, for example, the values that are reported in the Abt study are significantly different than those reported in the Harvard project. We believe the Abt study results must be considered when setting relative values for these services. (The results of the Abt study have been shared with this Subcommittee.)

As another example of flawed relative values, the vignettes that were used to collect estimates of time and intensity for general surgery services often did not describe the average Medicare case reported by a particular CPT code. In other words, the vignette that was used to determine the relative value for a particular CPT code reflected an amount of work at the low end of the range, rather than the average amount of work. If this problem is left uncorrected, the result would be a systematic undervaluation of the codes in question.

Let me give you two specific examples. The vignette that was used in the Harvard project to collect resource input data for CPT code 32020 was, "Chest tube insertion for spontaneous pneumothorax, in 20 year old." Clearly, there are very few Medicare patients who fit this description. In spite of this fact, however, the relative values for all of the services reported under this code are based on this vignette. In the average elderly Medicare patient, this procedure would be quite complex and involve considerably more effort during the post-procedure period than would be required for a younger patient. The CPT code applies to tube thoracostomies that are done for a wide range of indications, many of them serious, and could involve associated problems, such as infection and hemothorax.

Inguinal hernia repair (CPT code 49505) is the reference procedure for general surgery. The vignette that was used for this code in the Harvard project was, "Uncomplicated indirect inguinal hernia repair, 45-year-old male." By contrast, however, the procedure that is associated with this code is stated in the CPT-4 manual as, "Repair inguinal hernia, age 5 or over." Therefore, resource input data for an "uncomplicated" procedure that is performed on an otherwise healthy younger patient are proposed as the basis for determining the Medicare payment for the services that are associated with CPT code 49505. We believe the intra-service time that was reported by the Harvard project for the vignette (41.3 minutes in Phase I and 49.5 minutes in Phase II) is at the low end of the range of time that is required for services reported using CPT code 49505. A panel of general surgeons that was convened by the College at the request of the Physician Payment Review Commission (PPRC) concluded that a more reasonable average time would be 65 to 70 minutes or more. Procedure time data from two institutions support this conclusion. Data from the University of Cincinnati for inguinal hernia repair cases (excluding those procedures performed for recurrent hernias and cases where more than one procedure was performed) for all of 1990 showed that the geometric mean intra-procedure time was 100 minutes. Data from the Maricopa Medical Center in Phoenix for uncomplicated inguinal hernia repairs that were performed in December 1990 and January 1991 showed a geometric mean intra-operative time of 82 minutes. (These data were abstracted by hand from operative records at the hospital.)

Many of the other surgical vignettes that were used in the Harvard project are problematic in that they also resulted in the collection of resource input information about the care of younger, non-Medicare patients. That result would be acceptable if HCFA were proposing a physician payment system for other than Medicare patients. But, of course, HCFA is not. It should not surprise this Subcommittee to learn that the amount of care that is required by the average Medicare patient for at least some surgical procedures will be greater than the time that is required by the average non-Medicare patient. Medicare patients often have accompanying complications and comorbidities. Their lengths of stay often are longer, which obviously means that the amount of care provided by the surgeon during their inpatient stays will be greater than for patients who are discharged earlier. In addition, the amount of postoperative care often will be greater.

PPRC has acknowledged the need to assure that relative values reflect the actual work that is involved in caring for Medicare patients. The Commission discussed this issue in its 1990 and 1991 reports to Congress. In the 1991 report, the Commission made reference to a Medicare adjuster. By contrast, the proposed regulations are silent on this matter, even though HCFA received numerous comments with regard to this problem in response to the Medicare fee schedule that was published on September 4, 1990. We urge the Subcommittee to insist that HCFA address this issue prior to implementing Medicare physician payment reform.

The College also is bothered by the double standard that applies to many physicians' services under the proposed fee schedule. While the payment system is purported to be resource-based, many services are discriminated against. Policymakers speak of a resource-based system, but then propose to pay for assistants at surgery in a manner that is not based on the resources that are needed to provide the service. Policymakers speak of a resource-based system, but then propose to pay lower amounts to physicians for up to their first 4

years and 23 months of practice. We urge the Subcommittee to address both of these inequities.

The College believes very strongly that the same valuation rules (that is, resource-based relative values) that are adopted for physicians' services generally also should apply to assistants at surgery. In addition, the College believes that payment should be made for the services of assistants at surgery whenever these services are medically required in order to assure that Medicare patients receive optimum care. In our view, current Medicare payment rules that arbitrarily set the payment at 16 percent of the global fee and that deny payment if an assistant at surgery is used less than 5 percent of the time nationally are inconsistent with the theoretical underpinnings of Medicare physician payment reform, as well as good medical practice.

Similarly, we find it unconscionable to provide lower payments to newly practicing surgeons. Does anyone believe that new physicians have lower practice costs or malpractice insurance costs, or that they do not have substantial education-related debt, or that they somehow do not require the same amount of time and effort to perform a hernia repair or a cholecystectomy? Once again, if resource inputs are to be the determinant of value, then payment should not vary--and certainly should not be lower--for newly practicing surgeons.

We also are concerned that multiple operations, such as those that are required by trauma patients, may not get paid fairly under the policies that are proposed by HCFA, and we are continuing to examine this issue. Proposing to pay for multiple operations using an inflexible formula under which each succeeding procedure would be paid a smaller and smaller fraction of the surgical global fee once again violates the premise under which Medicare physician payment reform is based. Why not at least pay the full value of the intra-operative portion of each succeeding procedure, instead of some lower amount?

Care also needs to be taken to assure that the relative values for transplantation services are appropriate, especially since almost no resource input information was collected for these services, either as part of the Harvard project or any other government-sponsored effort. Preliminary analysis suggests that the proposed fee schedule would reduce payments for kidney transplantation about 30 percent below what they were two years ago (according to Medicare BMAD data), despite growing public interest in improving access to transplantation services.

Simply stated, to the extent that the process for setting relative values does not reflect fully the resource inputs that are associated with the care of Medicare patients, the premise upon which the entire system is theoretically based is violated. If Congress and the Administration believe that relative values for Medicare payment purposes should be based on resource inputs, then the American College of Surgeons must insist that surgeons be given "credit" for all of the resource inputs that are associated with surgical care.

Proposed Policy for Definition of Global Surgical Services

The College is deeply concerned about several other elements of the proposed regulations. We object to the double standard that relates to preoperative services. The proposed regulations would include in the global surgical fee the preoperative visits that may be required during the 30-day period prior to the operation. The regulations state that separate payment would be made for those visits that are provided by a surgeon to "seriously ill patients who need to be stabilized before surgery. . .*when documentation justifying the need for the surgeon's service is submitted*" (emphasis added). Special documentation requirements are **not** proposed when the same services are provided by someone other than the surgeon. In our view, this requirement will create an expensive, administratively burdensome system that has no purpose.

Moreover, the resource-based relative values developed under the Harvard project did not include preoperative visits within 30 days of operation. Yet, ophthalmologists must

treat glaucoma before they can perform eye operations; transplant surgeons must manage patients awaiting kidney transplant; and otolaryngologists must treat infection before proceeding to operation. The relative values that are proposed by HCFA do not include any resource inputs for these services, and separate payment may be denied under the definition of global surgical services, which continues to broaden in scope.

PPRC has concluded that only the preoperative in-hospital visits on the day of or the day before operation should be included in the definition of global surgical services. We believe that PPRC's approach is more practical and less discriminatory than the option that is recommended by HCFA. We ask this Subcommittee to urge HCFA to modify its definition of global surgical services accordingly.

However, we agree with HCFA's decision to provide separate payment for the initial evaluation or consultation leading to the decision to operate. And we also agree with the decision to allow separate payment for medically necessary return trips to the operating room to treat postoperative complications.

With regard to postoperative services, the College is not satisfied that, when the values for surgical services were determined, full credit was given for all of the postoperative visit services that now are included in the definition of global surgical services. Here again, the information that was used often pertained to the typical patient, not to the typical Medicare patient.

Conversion Factor

The American College of Surgeons also wishes to add its strong opposition to the behavioral offset that is proposed by HCFA. Among other things, HCFA has not given sufficient information to judge the reasonableness of the conversion factor before any offsets. In our view, this contrasts markedly with the amount of information that was released by HCFA in 1983 with regard to the budget neutrality calculations under the hospital prospective payment system. Many changes in payment policies are proposed that would reduce Medicare payments for physicians' services below what they would be, absent the fee schedule, and yet there is little evidence in the proposed regulations that all of these changes were taken into account in the budget neutrality calculations.

For example, the regulations propose to terminate or restrict payment for the following services, which currently are recognized for Medicare payment:

- prolonged physician attendance (CPT codes 99150 and 99151), "after hours" services (CPT codes 99050 and 99052), unusual travel (CPT code 99082), and extra supplies and materials (CPT codes 99070 and 99071);
- preoperative visits that are provided by a surgeon within 30 days of an operation;
- visit services that are provided following a minor surgical procedure or "scopy"; and
- subcutaneous, intramuscular, intravenous, and intra-arterial injections.

However, the proposed regulations include no information to indicate that HCFA took these payment reductions into account when the conversion factor was calculated.

As the original supporters of the MVPS concept, we believe that the MVPSs provide a new method of addressing concerns about volume and intensity. Moreover, HCFA has several other tools now in place, such as physician profiling by carriers, to specifically guard against medically unnecessary care.

When HCFA was faced with the budget neutrality requirement for the hospital prospective payment system, the agency did not make any payment offset, even though policymakers feared that the number of hospital discharges would increase under the new per-discharge payment system. Instead, HCFA took other steps, including implementing a system of monitoring admission patterns. More importantly, the feared increase in discharges never materialized. In short, we believe that the information that is available is too scanty to justify any behavioral offset in the conversion factor, especially given the long-term impact of such an offset. In addition, we find it demeaning that HCFA would assume that surgeons would perform additional or questionably necessary operations in order to replace lost income. If HCFA truly believes unnecessary treatments will occur, we do not understand how the agency can offer this physician payment reform plan to its beneficiaries.

We also wish to remind the Subcommittee that many surgical services already have experienced substantial payment reductions under past budget reconciliation acts. HCFA's fee schedule impact analysis overlooks all of these past reductions, and then projects **additional reductions** of as much as 35 percent. For example, coronary artery bypass procedures were reduced by 9 percent in 1990 and by an equal dollar amount in 1991. Yet, the proposed regulations project an additional reduction of 31 percent in payments for thoracic surgery by 1996.

A preliminary analysis shows that some of the Medicare fee schedule amounts that were published on June 5, 1991, are lower than Medicaid payments that were made in 1989 for the same services in many locales. For example, according to data included in PPRC's 1991 report to Congress, the median Medicaid payment in 1989 for a total hysterectomy (CPT code 58150) was $614. Under HCFA's proposed Medicare fee schedule, the national average fee schedule amount is approximately $592. Looking specifically at the state of California, the 1989 Medicaid payment for CPT code 58150 was approximately $810. By comparison, the proposed Medicare fee schedule amount for California for the same code is only $668, or about 18 percent less than the amount Medicaid paid in 1989. It also should be pointed out that, in two-thirds of the state Medicaid programs, the 1989 Medicaid payments for pediatric hernia repair (CPT code 49500) were higher than the proposed Medicare fee schedule amounts for the same procedure.

We believe these comparisons strongly suggest that Medicare physician payment reform is producing unreasonable payment reductions for many surgical services. These reductions are far in excess of those originally contemplated by the Congress and are in addition to those already mandated under previous legislation. In other words, what is being proposed are relative values that bear no relation to the absolute value of the services that are important to the health and well-being of Medicare beneficiaries.

Conclusion

In conclusion, the American College of Surgeons finds that much remains to be done before the new Medicare fee schedule will be ready for use. We hope that our initial views about the recently published regulations are helpful to the Subcommittee; and we look forward to working with the Congress, HCFA, and PPRC in completing a formidable agenda for fee schedule corrections, adjustments, and refinements.

Mr. McDermott. Thank you.

Mr. McGrath.

Mr. McGrath. Thank you.

Dr. Graham, you claim that HCFA's proposed geographic adjustment factors for physician payments are unfair to rural areas and result in fees that vary by as much as 30 percent between the lowest paid rural areas and the highest paid urban areas.

What is the solution?

Dr. Graham. We believe the solution to addressing that is some continued work on the technical factors having to do with the RVS equation itself. We do not believe that those can be solved by January 1. They have to do with the treatment of overhead in the calculation and have to do with the treatment of the area for which prevailings are calculated. You heard some discussion earlier about whether you would have single-State areas or whether you would have multiple-State areas.

Mr. McGrath. How would the recommendation that we reduce the number of statistical areas from 231 to 94 help that?

Dr. Graham. In general, when you tend to lump predominantly rural areas with predominantly urban areas for the purposes of running the calculations in the equation, the values for rural areas tend toward the mean; in other words, they do better.

Mr. McGrath. Dr. Austen, HCFA proposes to pay a global surgical fee, which you refer to in your testimony, for a service package that includes preoperative visits within 30 days prior to the operation. How would you recommend modifying this recommendation?

Dr. Austen. We were very satisfied with the PhysPRC's recommendation which, as I recall, the package begins after the diagnosis—after the decision regarding surgery is made.

Mr. McGrath. Going to the testimony we heard from Dr. Nelson, all of the physicians' groups are opposed to the 3 percent behavioral offset. The AMA seems to feel that the behavioral offset is a bogus way of calculating this conversion.

Given the constraints that you hear from Dr. Wilensky in terms of having this whole process be budget neutral, how do we get from where we are to where we need to be in a budget-neutral manner? As she has testified before, there is a behavioral modification percentage factored into all of the other recommendations that HCFA has given to us over the years. How do we get off that slide, if it is one, and get to where we need to be in a budget-neutral manner?

Dr. Austen. Sir, I think everything you have heard this morning would suggest that all of us, with the exception of HCFA, agree that the 3 percent behavioral offset is sensible.

Mr. McGrath. Well, let me say this to you. Sometime back we had a minimum wage bill in the House, and the administration was opposed to increasing minimum wages and, of course, labor was for it. The administration proposed to let the market take care of the increase, and, of course, labor's interest was well defined.

The administration then went to a compromise which increased it by half as much, which passed. It seems to me that you lose a little of your philosophy, maybe a little bit of your good argument, when you go along with the compromise. Nobody seems to feel, I guess, that 1 percent is a bad deal. But, you know, that can change

tomorrow. But once you have accepted that, you have lost your position.

I am just wondering how strong you are against 3 percent as opposed to 1 percent in determining the long-term effects of having the behavioral modification plugged into this factor. I wonder if you could address that.

Dr. GRAHAM. Sir, I think you have heard fairly clearly from all of us our preference is that this be implemented in year 1 and in year 5 with budget neutrality. In other words, you go back to the debate and the hearings before this subcommittee in 1988 and 1989. The description was of a constant-size pie for physician payment which was going to be redistributed. The proposal which the administration has placed before you now arbitrarily reduces the pie by $3 billion in 1996 and makes further reductions over the entire transition. Our very strong preference is to go back to the constant-size pie and have that redistributed within.

Mr. MCGRATH. There is a question as to at what point it needs to be budget neutral. Does it need to be budget neutral in the formulary itself or at the end of the entire process?

Dr. GRAHAM. I think we would argue the intent of the Congress was neutrality would be maintained throughout the process.

Mr. MCGRATH. We are going to have to find that out because there is some question as to whether or not that was the intent in the beginning. I would just caution you that it is easy to accept compromises in your own benefit. We have changed our health policy in this country from 1949 when we encouraged people through Hill-Burton money, and now we are cutting back on the capital in terms of folding it into the DRG. I mean, that is going from one end of an incentive to another end, which is a disincentive.

I think your principle here, if you are really convinced that it is a principle which is worth hanging on to, would be to fight based on the fact that this factor should not be in the calculation of the conversion factor. That is my own personal opinion. I think you lose part of the principle and part of your argument when you accept something that might be beneficial to you in the short run. But I guess that is what the house of delegates is all about.

Thank you.

Mr. MCDERMOTT. Mr. Cardin.

Mr. CARDIN. Thank you.

Dr. Graham, I want to follow up on the comment of Congressman McGrath in regards to the geographical adjustment factors. It is my understanding that as part of the reform that one of the factors that we wanted to take into consideration was the difference in costs in different regions and that the geographical adjustment factor is a way to get at that particular issue.

Your position or the position of your group is that that not be done based upon the concern about underserved areas, which is a real concern. But I am wondering how much we really get at the underserved areas by having a uniform reimbursement schedule versus trying to look at that as a separate problem. I would just appreciate a little bit more comment as to your thinking as to why we should have a uniform fee around the Nation without any geographical adjustments as being fair.

Dr. GRAHAM. Based upon the modeling that we have done and the way that we have followed this history through all of the UCR basis of payment, we currently have a circumstance where physicians practicing in rural areas, many of which are underserved, have substantially lower fees than physicians providing the same sets of services and practicing the same specialty in more urban areas.

We felt that the RVS was going to move us towards a principle of equal fee for equal service. The fact that it is a very complicated equation results in an outcome where we have moved only partially in that direction. The equation would treat rural physicians better now than they would have been under UCR, but not still equivalent to their peers in urban practice.

Mr. CARDIN. But if you are in family practice or are an internist and you are in an area where your overhead is much more costly than in other areas, aren't you compromising the ability of family practice or internists in those areas where the rents are more or overheads are more?

Dr. GRAHAM. Well, I see Dr. Cleaveland perhaps moving. We have found, interestingly, as we have done some analysis of our own members' practices, that the assumption that rural is cheaper is not necessarily the case. Indeed, some of the highest overhead percentages in terms of total practice costs we find in rural areas because those physicians have to have everything in their office. They don't have something down the street.

Mr. CARDIN. I will let Dr. Cleaveland respond also. So your concern is that the adjustment won't be made fairly or can't be done under the system? Because I would think that the geographical adjustments would take into consideration the costs in rural areas. If it is more for various reasons, to get competent help or whatever and you have to pay more, that would be taken into consideration.

Dr. GRAHAM. The concerns which we have tried to raise in the testimony—and acknowledging this is not a 1991 fix, this is something we need to keep working on—is progress has been made in bringing things even. We don't think sufficient progress has been made, and it needs to continue to be worked on.

You did ask the question earlier should we do it all through the equation or should we provide some specific incentives. We would never want to set aside the fact that for certain areas and certain populations, even when we have perfected an RVS, we may still need to provide incentives. That may be a very important public policy step.

Mr. CARDIN. Dr. Cleaveland.

Dr. CLEAVELAND. The problem of overhead really has a curious leveling-out effect. We have to bid against the best salary available for qualified laboratory and x ray people. So in a medium-sized city, my overhead will more closely approach that of, say, Atlanta and Birmingham and large cities nearby because there is a small pool of qualified, licensed assistants for a medical office. So our overhead drives consistently toward the same 60 percent mark that my colleagues in large cities have.

One of our areas of concern is that of practice costs, and we think that practice costs tied to historical charges really don't measure the resources used. And that is what is failing right now,

is to determine scientifically exactly what an expected overhead is going to be this year and in 5 years down the pike as the payment reform takes full effect.

Mr. CARDIN. Thank you.

Mr. MCDERMOTT. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

I would certainly hope that we wouldn't move away from geographical variation at this time. I talked with a group of black obstetricians here in Washington, DC, and I was just absolutely stunned to hear the differential in malpractice costs between practicing in D.C. and just over the river. I am sure that is true in all specialties. The dean of Howard University commented last week in the newspaper on the serious underserving of D.C. residents, and one of the factors in propelling that underserving was the differential malpractice costs. That is only one of the more obvious differences in practice costs that has a geographical base. But I think until we adopt some other reforms, we can't neglect a geographical adjuster.

In that regard, I guess my question goes to the larger issue of volume control. What we are involved in here is discussion of how to adjust for volume in a system that is managing costs through fee management, basically. We have had a lot of experience with this approach, actually. We have managed costs through reimbursement rates under Medicare and Medicaid. Over the course of many years, we have clearly affected access, and I would say, in my judgment, we have affected quality as well.

But there are some other approaches to controlling volume that are receiving a good deal of attention in Washington, and I would just like to know what you think about them. The other approaches to affecting volume have to do with changing the incentives throughout the system, in the Tax Code and in other places, so that we stimulate a different approach to buying health care, one that reduces the incentive to buy volume. That is, we promote the expansion of managed care through both tax structure and copay-structured plans and we reform the malpractice system to reduce volume-driven decisions, and those kinds of restructuring of our system. The two most dramatic examples are managed care and malpractice reform.

I wonder what impact you think those things would have on volume as opposed to the impact the fees will have on volume. Are they more or less powerful tools in addressing volume?

Dr. CLEAVELAND. I think that fees will not have that great an impact on volume in internal medicine because the increases are so modest. You touched upon the malpractice cloud, and although I live in a State which has a relatively low malpractice premium, I assure you that that is one of the powerful clouds that hangs over us all, and I think more than any other factor serves to drive costs higher and higher.

Mrs. JOHNSON. Just to follow up on that, does it drive costs only because of the premiums, or does it drive decisions?

Dr. CLEAVELAND. It drives decisions, because the power of defensive medicine is enormous, and there is this sensation that you must constantly cover yourself against every possible bad result.

We have very little experience in Tennessee with managed care, and I can't really comment on that.

Mrs. JOHNSON. But you would say that our liability system, which, of course, is unique in the world, does have an impact on volume?

Dr. CLEAVELAND. Yes, very definitely.

Dr. GRAHAM. I guess to give a quick response to a very complicated question, the issues that you raise about other controls of volume or total expenditure probably have to be addressed in the context of a total financing system, where who pays under what circumstances. There is no question that the resource utilization in managed care is very different, but also the mixture of what you might call economical inputs is very different. The percentage of physicians and their specialty and the number of visits per year is very different. So it becomes very complicated to say what is influencing volume.

I agree with Dr. Cleaveland. For the purpose before us today in discussing this particular regulation, we are very skeptical of HCFA's assumption about the effect on volume of changes in fees, which is one of the reasons that we advocate that that not be considered.

Dr. AUSTEN. I think I would be very brief and say I agree with certainly what has been said. One of the groups that I presume would be assumed to increase volume would be the surgeons since the surgeons are going to take, I guess, one of the major hits. Maybe there is something I don't understand, but as far as I know, we don't go out in the street and tackle patients for surgery. They are referred to us. Patients only have one gall bladder to be done. They don't have two. And so I must say we are very skeptical as well in terms of the magnitude of the volume offset that they are discussing.

Mrs. JOHNSON. In that regard, it is interesting that those volume offsets come from 1970s research.

Dr. AUSTEN. Yes.

Mrs. JOHNSON. These physicians were practicing in a very different context, both from the point of view of reimbursement resources and utilization oversight. So I hope we will be able to get a better handle on the volume issue before we go too far down this line.

Thank you.

Mr. MCDERMOTT. I would just like to ask you the question: You don't like the prospect of being spanked before you go to school in anticipation of something you might do during the day. But the law limits the amount—that was his analogy?

Dr. GRAHAM. I thought it was a great line, but it is his. [Laughter.]

Mr. MCDERMOTT. The law limits the amount that we can reduce you. If the volume grows by more than 2 percent, we can only reduce it 2 percent the following year. Would your societies be in favor of or be willing to trade the lack of prospective anticipation in exchange for no limit on how much you could be reduced in the next year? For instance, if you went up 5 percent, would you accept the 5 percent reduction in this following year?

Dr. CLEAVELAND. I would see that as a reasonable tradeoff. The thing that bothers me is the notion that I am going to be guilty of a transgression before the event. That puts a basic seed of mistrust in the negotiations before we ever get away from the starting line. That is almost offensive.

Dr. GRAHAM. Let me be a little more cautious but in the same direction. We are here today to express concerns and a willingness to try to find ways to work it out. If the committee comes to a conclusion that there are alternative policies that get it done, we will come to the table and talk about it. If you say it is open-ended, my question would be: Is it tied to performance, and is that performance tied to specific public policy goals? If all three of those things are met, that may be a very reasonable approach.

Mr. MCDERMOTT. I think the issue of whether this is going to be budget neutral is the question that we are struggling with. And I suspect if Dr. Wilensky were still here, she would say we are anticipating a problem so we thought we would begin early on it.

Dr. GRAHAM. That was very clear.

Mr. MCDERMOTT. But if there is an understanding that if it goes out of hand that it will be corrected in the next year without any further hearings on it——

Dr. GRAHAM. Well, the use of the MVPS has an additional logic to us, and that is, in addition to being based upon actual experience, it does treat two classes of services differently, because you have an MVPS for evaluation and management—excuse me. Actually, I guess it is an MVPS for procedures and then all other. And so if you have differential behavior with indifferent groups, you can respond to those groups and that behavior differently rather than what we have right now, where an anticipation is being made and then everybody is being tarred with the same brush. So it seemed far more sensitive.

Dr. AUSTEN. Well, as you know, we in surgery have been, one, supportive of a Medicare volume performance standard and, second, have fought very hard to have one for surgery. The reason we have done so is not to be exclusive but because we think as a group, a reasonable size group, that we have a chance of really influencing the behavior of the surgeons of this country, something that we think as a surgical group it would be very hard to do if we were part of the whole pie. So we are very optimistic that we can have an effect on the volume by this mechanism.

Mr. SHAPIRO. Mr. Chairman, if I could just correct the premise of your question, Congress can set the update at whatever rate Congress wants to set it at. As always, Congress can do what it wants to do. It is only if the default mechanism becomes operative where there is a limit in the amount of the correction. If Congress doesn't act, it is 2 percent and then moves to 3 percent.

Mr. MCDERMOTT. I have one further question, and this is a little bit more philosophic and it is really directed at the general practitioners and the internists. The cost of medical education, to what extent—both of you have enough gray hair that your education is probably paid for by now. But most people coming out of medical school today are carrying rather sizable debts. Tell me what you see as the impact of this whole change in payment schedules in terms of people's choice of specialty.

Dr. CLEAVELAND. Mr. Chairman, I don't see how some graduates even carry the paper on the debts that have stacked up in medical school, $50,000, $80,000, $100,000 debts. In fact, I think department chairmen in medical schools need to take their students aside first of all and give them a lesson in financial facts of life along about the first or second year. This very much drives career decisions further on down the pike, and I think it leads a number of people to forego their residency plans and go off into emergency medicine careers, to take positions in small community hospitals looking after the emergency rooms. It really forecloses consideration of primary care specialties to a great extent.

Such debts are no longer a rare phenomenon. They are quite commonplace.

Dr. GRAHAM. I am not sure we disagree, but I would respond differently. We get very mixed signals from students as to the influence of debt on career choice. Indeed, I believe the literature is very complicated. Fifty percent of medical students graduate today with $40,000 of debt or less; 20 percent graduate with no debt. AAMC studies from graduates of 1990 indicate that there is no correlation whatsoever between career choice and level of debt. At the same time——

Mr. MCDERMOTT. Do you believe that?

Dr. GRAHAM. I believe their data, but I also talk to students extensively, and that is why I say it is a very complicated decision. And where I would agree is that I believe what the RVS holds in store is an explicit revaluing of professional skills. And there are a lot of things going on with a medical student, but if somebody says, Would you like to be a family physician, train for 3 years, go out into the community, work 70 hours a week, and earn one-fourth of what somebody who trains for 3 or 4 years and works 50 hours a week, and they say that doesn't seem fair. And it is not just the money; it is not just the debt, although that factors into it. It is the implicit valuing of my services and my skills within the medical community.

One of the key things about RVS I think is saying there are major contributions being made through evaluation and management. We are going to raise that floor a little. We are going to pull the ceiling down a little bit. If you can do that, some of the issues of debt I think become more manageable.

Mr. MCGRATH. Mr. Chairman, may I comment?

Mr. MCDERMOTT. Sure.

Mr. MCGRATH. I have been visiting medical schools and hospitals all over the State of New York. If there is one thing that the medical school faculties are telling me, it is that we need to concentrate more on preventive medicine, primary care, and family practice. They are all real clear in terms of the effect of the incentive of higher reimbursements for the family practice, general practice, and internal medicine on going into that kind of a specialty rather than the specialties that generally have been more heavily reimbursed in the past. They also tell me that the debt that is incurred by medical students early on is a primary determinant in the specialties that they will choose later on in their careers.

So I think it is very important that we, first of all, settle this argument we are having regarding the worth of this relative value

scale. Second, we should take some remedies to put off at least the payment of the interest on the debt for these students until somewhere down the line where they can afford it, rather than having to pay it on some resident's income when in a lot of cases the payment of that debt represents 50 percent of their income.

Mr. SHAPIRO. Mr. Chairman, if I may, Mr. McGrath, we appreciate that statement very much, and if you could talk to your colleagues on the Education and Labor Committee who are now considering reauthorization of the Higher Education Act, the issue of student loan deferment for medical residents is a part of that act.

As you know, medical students are no longer allowed to defer their loans beyond a 2-year period. We are seeking to restore a full deferment through the residency period. Your help would be tremendously appreciated in that effort.

Mr. MCGRATH. How much does it cost? [Laughter.]

Mr. MCDERMOTT. I was going to ask that next.

Mr. SHAPIRO. In the context of the Higher Education Act, it is a very small issue.

Mr. Chairman.

Chairman STARK [presiding]. While we are on that subject, I am not going to ask you to——

Mr. MCGRATH. Excuse me, Mr. Chairman. May I interrupt? The House has just gone in, and I have to leave for an appointment. I am wondering how we are going to proceed.

Chairman STARK. It would be the intention of the Chair to work straight through. If there are votes as we go in, we will try and just adjourn briefly if we have to, but will return as soon as we can.

Mr. MCGRATH. There are two more.

Chairman STARK. Two more?

Mr. MCGRATH. Two more.

Chairman STARK. I am sorry.

Mr. MCGRATH. It was my understanding that we were going to move to another room at one time or another.

Chairman STARK. If the gentleman will suspend for a moment. [Pause.]

Chairman STARK. We have until 1:30 in this room, and then we would go to 1310, if need be, to conclude. We may very well get through. That would be the intention of the Chair.

Three quick questions to the panel. You raised the question of education. Indulge me for a moment, and without explaining to me why this is the worst idea that the world has ever heard of, but let us assume for a minute that we had a single payment system in the United States. This would work even if we didn't, but let's assume this would make it much easier. Then we would say that anyone who matriculates at a medical school may elect to receive a Federal grant, and we put medical schools on a pay-as-you-go basis and get all this business out of Medicare. So let's say medical school costs and training, right on through graduate medical education, is $30,000 to $40,000 a year. You as a student may elect to receive that from the Federal Government if you make it into school.

At the conclusion of your training, whether you finish or not, if you elect a semester here and a semester there, you would receive a reduction in your fees received from a single payer for the rest of your life of 1 or 2 percent, and we would have a self-funding pro-

gram. The other side of that is you would pay a higher Social Security tax, for the rest of your life, which would go into a fund. So if you became a surgeon, like my friend, Gerry Austen, you would pay more in over your career. If you became a pediatrician like some of his colleagues, you would earn less and you would pay less into the fund. But the selection of the student would be blind. The student, if he chose, if he had some ability to save some money, wanted to work his way through school, he could pay his own way or borrow money if he didn't want to put that blight on his income for the rest of his career.

Could you live with that? You are all educators and/or have been through the process.

Dr. CLEAVELAND. I very much could live with that. That is, in effect, what I did with national student defense loans back at a time when that would constitute about 75 percent of my yearly tuition. That was back in the $1,200-per-year tuitions, and a $1,000 national defense loan went a long way to accomplishing that. And I paid it off over 10 years.

Chairman STARK. If Gerry and I had been old enough, we would have gotten $100 a month for GI benefits when we were in school.

Dr. AUSTEN. It sounds really quite interesting.

Chairman STARK. You can do it without single payer.

Dr. AUSTEN. I think you would have to sort of look into it carefully, but it sounds interesting.

Dr. GRAHAM. Basically what you are proposing without a single payer is a loan repayment program, and that has been something we strongly support.

Chairman STARK. Would you all support legislation that would overturn the gag rule as related to the recent Supreme Court decision on your ability to offer advice?

Dr. AUSTEN. Yes.

Dr. CLEAVELAND. Yes.

Chairman STARK. You would support it. Thank you.

Third question. There was an earlier statement implying that if the problems that we are discussing today aren't somehow worked out, a leading advocate of physicians would seek higher extra billing limits.

Now, that is saying to me that if you and I and HCFA can't work out our problems, we are going to stick it to the beneficiaries. I don't see any other result that if we can't work out a fair payment thing, we are going to raise the extra billing limits. Is that anything that you all would subscribe to, or do you think we can iron out our differences and the patients ought not to be party to this discussion?

Dr. CLEAVELAND. I presume that we are in the process of ironing out our differences by the very nature of this hearing, and the thing that I am impressed by is that the different viewpoints are receiving a respectful hearing. So the other is an alternative that does not come into play.

Dr. GRAHAM. We had lengthy discussions about that in 1989, and we accept the provisions in the law, and we would have no reason—as they relate to balance billing, we have no reason to try to solve them.

Dr. AUSTEN. Same.

Chairman STARK. I want to thank you, as well as the previous witnesses. This has been enlightening—particularly for those of us who don't even begin to understand, with the exception of Dr. McDermott, either how you prepare or how you proceed to ply your profession. Those of us who are mostly counting beans, tiptoe in this mine field pretty gingerly. It is your willingness to work with those of us who are not quite so sophisticated in the ways of what the medical delivery system is all about. We appreciate it.

The principal concern the Chair has in this hearing is that we have from time to time negotiated deals, for lack of a better word, and the most important thing is that if we can't continue to do that—we can have disagreement. I presume we will. The taxpayers' interest may be at odds with your interest, certainly. Sometimes the taxpayers' interest is at odds with my interest. But that is easy to deal with. We can compromise. It is only when we can come to the table and work these differences out that a system will work. This system is pretty fragile right now. It is pretty new. I would continue to say that the genesis of these hearings is to suggest that the committee's reputation, not the Chair's or any individual member's, is in question. The question is, can we make an arrangement and stick to it and see it through?

I intend to see that we will do everything we can to work toward that goal. Your patience at this point is appreciated. Thank you very much.

Mr. Cardin, have you inquired?

Mr. CARDIN. I have no questions.

Mr. Chairman, I did want to point out that on the next panel, the first person you will be introducing, Dr. Jensen, is from Baltimore. I just wanted to point out that, once again, the chairman is using people from Baltimore as expert witnesses here. I want to welcome Dr. Jensen to the committee.

Chairman STARK. We had hoped that he would have driven to work with you this morning and saved the committee the transportation fees for the witnesses.

Mr. CARDIN. Well, I did warn him that his friendship with me would not save him in the questions from the Chair.

Dr. JENSEN. I came on the MARC.

Mr. MCDERMOTT [presiding]. The committee is pleased to welcome Dr. Jensen, who is the associate secretary of Federal economic policy for the American Academy of Ophthalmology; Dr. Rufus Stanley, chairman of the Committee of Health Care Financing of the American Academy of Orthopedic Surgeons; Dr. Alan Bennett, member of the board of regents of the American Urological Society; Dr. Robert Jamplis, president of the Society of Thoracic Surgeons, from Palo Alto, and Dr. Jamplis is accompanied by Dr. George Miller of the Government Relations Committee of the Society of Thoracic Surgeons.

We want to welcome you. Your entire testimony will be entered in the record. We would ask you to summarize your testimony in 5 minutes so that we will have time for questions.

Dr. Jensen, do you want to begin?

STATEMENT OF ALLAN JENSEN, M.D., ASSOCIATE SECRETARY FOR FEDERAL ECONOMIC POLICY, AMERICAN ACADEMY OF OPHTHALMOLOGY

Dr. JENSEN. Thank you. I am Allan Jensen. I am an ophthalmologist in private practice in Baltimore, and I am secretary for Federal economic policy of the American Academy of Ophthalmology. The academy represents 90 percent of ophthalmologists in the United States, and we are some of the medical specialists who will shoulder a significant burden of the reductions under the new fee schedule. We thank you for inviting us to testify.

We submitted the written statement, so I will summarize my comments: first, on the conversion factor, on policies relating to global fees, on internal HCFA policy development that should be part of the public process, and on the recommendation for an outlier policy similar to the hospital DRG system that could provide a safety valve to compensate for shortcomings of the Harvard study.

We certainly share the frustration of our colleagues with the use of the fee schedule to gain deep cuts in physician payment, and while we certainly were expecting reductions, we were surprised at the magnitude of the cuts. We could not have predicted these levels even when the publication of the September 1990 fee schedule came out. We join with the AMA and others in urging you to instruct HCFA to recompute the conversion factor.

As an aside, when we were talking about volume and anticipated volume increases, the question was asked about what other ways might we control volume. And I think we should give careful consideration to effectiveness research, and the American Academy of Ophthalmology is one of the first subspecialty groups that has created preferred practice patterns in an attempt to educate our members to make certain that the services we are providing are effective, and hopefully in that way can put a control on volume.

We also oppose HCFA's definition of the surgical global fee. In its effort to nationalize a global fee policy, HCFA has gone far beyond current practices. We participated in a PhysPRC consensus panel developing a surgical global fee policy and in general support PhysPRC's version which was incorporated into phase II of the Harvard study.

We are concerned that HCFA's drastic change will result in further reductions in payments related to surgery, not only to the surgeon but to other providers, which could impact not only quality of care but even deny care in some instances.

We urge you to instruct HCFA to adopt the PhysPRC parameters for the global fee policy and also to prohibit billing by limited-license practitioners before the end of the global fee period.

Under the schedule, minor surgeries would be subjected to a 30-day global period, and no payment for office visits would be allowed. This again contradicts the survey parameters and the assumptions used by Harvard and would significantly underpay minor surgeries.

HCFA should take this into account and either add in the value or pay separately for appropriate office visits associated with minor surgery.

HCFA will be developing internal lists to assist carriers in implementing the new policies. These lists will take on as much importance as the rules themselves and should be open to public scrutiny with a comment period and accountability.

The academy was recently involved in an exercise initiated by HCFA to develop a list of services to be included as part of the surgical global package. A computer printout was circulated to the AMA CPT advisory panelists for review, with a short turn-around time and with no input expected from the specialty societies. That list is now apparently in the hands of the internal HCFA consultants who apparently have not accepted the comments we have made and are not likely to respond.

We feel that more sunshine should focus on this process, and we urge you to direct HCFA to open these important policymaking functions to full public involvement.

There were many methodological problems with phase I of the Harvard study, and Dr. Hsiao acknowledged these shortcomings, and ophthalmology was restudied under phase II. While Dr. Hsiao corrected some shortcomings, his work was a disappointment, not only because of some antisurgical bias that remained, but because many of the methodological changes appear to have been given only cursory attention.

We still have not received the final restudy. An important element relating to retinal services is just being completed. But the earlier scrutiny does reveal that some data trimming went too far. In the Harvard study, initial survey results go through statistical transformations, and many values are deleted in order to establish an average result, sometimes deleting too many values.

A case in point is the estimate of the magnitude of a retinal detachment repair. The initial average response said it was 21 times more difficult than the base procedure. After the various transformations, trimmings and rescalings, Harvard left it as only 6 times as compared to the 21 times more difficult than the base.

The overtrimming of nonaverage responses and the apparent lack of meaningful utilization of subspecialty data could mean that there are significant undervaluations of some procedures. However, the proposed schedule has no policy for dealing with outlier cases. Some specialists treat most of these outliers, and some outliers might have difficulty receiving care under the proposed system. The hospital prospective DRG system has an outlier system for cases which significantly exceed the average care. We recommend that Congress instruct HCFA to develop a similar safety-valve outlier system for physician payment under the fee schedule to help maintain access.

Thank you for the opportunity to comment, and I will be glad to answer questions.

[The prepared statement follows:]

Testimony of the American Academy of Ophthalmology
Before the House Ways and Means Subcommittee on Health
on the Proposed Medicare Fee Schedule
June 25, 1991

My name is Allan Jensen, M.D. I am an ophthalmologist in private practice in Baltimore, Maryland, and am the Associate Secretary for Federal Economic Policy of the American Academy of Ophthalmology. The Academy represents 16,000 or 90 percent of the ophthalmologists in the U.S., medical specialists who will shoulder a significant burden of the reductions under the new Medicare Fee Schedule.

Thank you for inviting us to testify before the Committee. The Academy does not support the intent of the Harvard methodology, with its inherent bias against surgery and high technology procedures. Ophthalmology has made great strides in treating previously untreatable blinding conditions using new surgical techniques and technological advances. We are concerned that the new Medicare Fee Schedule will thwart advancement because of the extremely low reimbursement rates. We hope you will consider the impact of this fee schedule beyond the Medicare budget.

We will focus our comments on these areas: the impact of the conversion factor; new policies relating to the surgical global fee; internal HCFA policy development that should be made part of the public process; and the recommendation for an "outlier" policy similar to the hospital DRG system that could provide a safety valve to compensate for the methodological shortcomings of the Harvard RVS study.

Unexpected Reductions Due to the Conversion Factor

We share the frustration of our colleagues with the Administration's use of the new fee schedule to gain deep cuts in physician payment. HCFA's manipulation of the conversion factor contradicts Congressional directives for budget neutrality.

While we were expecting reductions--based on the bias of the system against surgical procedures--we were surprised at the magnitude of the cuts. We could not have predicted these levels, even with the publication of the September 1990 Model Fee Schedule.

Earlier this year, we projected values based on the Harvard re-study of ophthalmology, and incorporating the September Model Fee Schedule assumptions. Then we reduced those projections by 15% to account for a "worse-case" conversion factor. Even so, the June 5 numbers are about 20% less than our projections. This is directly attributable to the gamesmanship by the Administration in developing the conversion factor.

We urge the Committee to instruct HCFA to recompute the conversion factor as recommended by the AMA.

Surgical Global Fee Policy

We also oppose HCFA's proposed definition of the surgical global fee. In its effort to nationalize a global fee policy, HCFA has gone far beyond current local practices.

In 1989, we participated in a PPRC consensus panel developing a surgical global fee policy. In general, we support the PPRC's version, which was incorporated into Phase II of the Harvard RVS study.

The key differences between PPRC and HCFA policies are:

1) For pre-operative care, HCFA would include all visits by all physicians for 30-days before surgery, where PPRC and Harvard include only the day before surgery into the global fee. PPRC's policy allows for separate billing of necessary pre-operative testing and evaluation, by the surgeon or other providers, prior to surgery, which HCFA would not allow. Medicare patients often have high blood pressure, diabetes, heart conditions or other conditions that need to be assessed before surgery. Under HCFA's policy, the internist would not be paid unless the patient was very seriously ill.

2) HCFA would include in the global fee <u>all</u> services performed during the post-operative period up to 90 days from the date of surgery. PPRC would include post-operative visits, but would allow other procedures to be billed separately. Harvard followed this approach in its Phase II survey. The RVS vignettes were designed to represent the average, uncomplicated case. HCFA's proposal to include all complications contradicts the intent of the RVS pricing, and unfairly reduces reimbursement for complex, severe or complicated cases.

We are concerned that HCFA's proposed drastic change will result in further significant reductions in payments related to surgery, to the surgeon and to other providers, which could have an impact on the quality of care.

We are also concerned that despite HCFA's apparent zeal to bundle services, it continues to allow optometrists to bill for seeing patients during the post-operative period.

We urge Congress to instruct HCFA to adopt the PPRC parameters for the global surgical fee, and to prohibit billing by non-M.D.s before the end of the global fee period.

<u>Minor Surgery Global Policy</u>

Minor surgeries would be subjected to a 30 day global fee period, and no payment for office visits would be allowed, under HCFA's proposed rules. This again contradicts the survey parameters used by Harvard, and would significantly underpay minor surgeries.

Harvard did not survey or develop estimates for pre- and post-service work for minor surgeries, because the researchers assumed that office visits would be billed in addition to the minor surgical procedure. HCFA should take this into account and either add in the value or pay separately for appropriate office visits.

<u>The HCFA "List" Policy</u>

HCFA will be developing internal lists to assist carriers in implementing the various new nationalizing policies. These lists will take on as much importance as the rules themselves, and should be open to public scrutiny, with a comment period and accountability.

For example, the Academy was recently involved in an exercise initiated by HCFA to develop a list of services to be counted

as part of the surgical global "package". A computer print-out was circulated to the AMA CPT advisory panelists for review, with an extremely short turn-around time, and with no input expected from the specialty societies. The list is now apparently in the hands of the internal HCFA medical consultants, who apparently have not accepted the comments we made, and are not likely to explain why our comments were rejected.

During the next few months, HCFA will be developing the following policy lists:

* bundle of services in the surgical global fee
* minor surgery procedures
* outpatient surgeries subject to an overhead reduction when performed in a hospital setting
* outpatient surgeries that could be performed in an office setting
* special higher-cost supplies for certain procedures performed in the office, with national fees developed for those supplies
* diagnostic tests with technical components and the value of those components

All of these lists will be developed by HCFA as carrier guidelines. More sunshine should focus on this process--the lists and other implementation policies should be included in the Federal Register for public comment, and HCFA should be required to address the comments. There is precedent for this under Medicare Part B in the periodic publication of the ambulatory surgery centers list of covered procedures.

We urge Congress to direct HCFA to extend these important policy making functions to full public involvement.

Harvard Methodology Questions

There were many methodological problems with Phase I of the Harvard RVS study, completed in 1988. Dr. Hsiao acknowledged these shortcomings, and ophthalmology was re-studied under Phase II. Dr. Hsiao corrected some shortcomings, but his work was a disappointment, not only because the strong anti-surgery bias remained, but because many of the methodological changes appear to have been given only cursory attention.

Further, we have not yet received the final Harvard ophthalmology restudy. An important element relating to retinal services is just being completed. Some early scrutiny reveals:

* Data "trimming" went too far. In the Harvard study, initial survey results go through statistical transformations, and many values are deleted in order to establish an average result. Our economists have questioned whether Harvard deleted too many values.

  A case in point is the estimate of the magnitude of a retinal detachment repair. The initial average response said it was 21 times more difficult than the base procedure. After the various transformations, trimming and rescaling, Harvard left it as only 6 times more difficult than the base.

* Cross-linkages: While the crosslinks used in Phase II appear to be adequate, our technical consulting group, under Harvard's direction, took pains to select vignettes with CPT codes which might also be used by other

specialties, such as plastic surgery, otolaryngology, or general surgery. Harvard neglected to include any of these vignettes in the other specialties' studies.

* Subspecialty surveys were a new feature of the Phase II ophthalmology study, allowing more procedures and ophthalmologists to be included. However, only the general survey was used in the cross-linking and rescaling. It is possible that by excluding the values of the subspecialists, Harvard missed important, more severe or intensive patient vignettes. The result could be an undervaluing of our scale, and a lack of recognition of these special cases.

* "Consensus" Process: Harvard is conducting a Phase III study, aimed at filling in values for non-surveyed procedures. One of our technical panelists takes exception to the term used by HCFA and Harvard that Phase III involves "consensus." He said that they were provided mail surveys for individual response. However, when they met in person, the session was not conducted in a manner to establish consensus on issues, and the panelists said they felt their recommended changes would not be incorporated.

The over-trimming of non-average responses, the apparent lack of meaningful utilization of subspecialty data, and the questionable treatment of recommendations by the consensus panel could mean that there are significant undervaluations of specialized procedures. However, the proposed Medicare RVS Fee Schedule has no policy for dealing with "outlier" cases. The hospital prospective payment DRG system has an outlier system for cases which significantly exceed the average care. We strongly recommend that Congress instruct HCFA to develop a similar safety-valve "outlier" system for physician payment under the Medicare Fee Schedule.

Thank you for the opportunity to comment. I would be happy to answer your questions.

Mr. McDERMOTT. Dr. Stanley.

STATEMENT OF RUFUS F. STANLEY, JR., M.D., CHAIRMAN, COMMITTEE ON HEALTH CARE FINANCING, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. STANLEY. My name is Rufus Stanley, Mr. Chairman and members of the committee. I am an orthopedic surgeon in Houston, Tex., and I am here today as a representative of the American Academy of Orthopaedic Surgeons. The AAOS has in its membership something in excess of 14,000 board-certified orthopedic surgeons. Thank you very much for letting us present a few of our views regarding the proposed fee schedule.

You have my written testimony, and due to the constraints of time, I will mention only four facets of the rule, those being the proposed conversion factor, defining the global service packet, payment for multiple and bilateral surgical procedures, and payment to new doctors in the Medicare program.

We agree fully with the contention of the American Medical Association that the proposed conversion factor has been pared to what we would regard as an unrealistic and, quite frankly, a bit of a shocking degree. We share the concerns of the country, we want you to know, regarding the rate of growth in health care expenditures, certainly including those of part B Medicare, and we want to be part of the solution.

But frankly, Mr. Chairman, many of us in the surgical specialties are wondering with a degree of awe how we can possibly increase the volume and/or the intensity of our services to accomplish, recapture, if you will, 50 percent of the presumed loss as a result of the Medicare program.

Chairman STARK [presiding]. I had my tonsils out twice.

Dr. STANLEY. Sorry, sir?

Chairman STARK. I had my tonsils out twice. [Laughter.]

Dr. STANLEY. That is a bilateral procedure, Mr. Chairman, as you very well know. [Laughter.]

While I am struggling with the math, quite probably obviously, the assumptions are coming a bit more easily. In my opinion, the assumptions are wrong, and we urge that you bring some reason to this debate.

Second, we urge that you heed the advice of the Physician Payment Review Commission regarding the definition of services to be included in the global service packet. For example, the idea of defining the beginning of a payment service period as the time when the decision for surgery is made would not and does not, in our opinion, provide a uniform, consistent, or distinct benchmark for payment, and in our opinion would pose significant difficulty and some conflict between patients, their insurance carriers, and providers.

Further expanding the definition to include a 30-day preoperative period is in our opinion unrealistic. It is a bit confusing, we think, and would be administratively burdensome. As you very well know, patients change their mind about whether to and when to have elective surgery. So do surgeons. And, God willing, we will continue to do so as time goes along. We hope that you will share

our concern and will join us in our desire to reverse this proposed policy.

Our primary concern regarding the diminishing-return system of payment for multiple surgical procedures stems in part from our responsibility for the care of the beneficiary who has sustained multiple injuries. An example, I think, is afforded by the case of the older patient who has had the misfortune of being involved in an auto accident and has sustained fractures to the arm, the forearm, the thigh, and the leg. The determination of the sequencing of the repair of the injuries quite obviously has to be based on medical and surgical principles, not payment principles. But whether procedure number four—in this example—involves the arm, the forearm, the thigh, or the leg, remuneration at 10 percent frankly seems a bit ludicrous. The Health Care Financing Administration says, "We do not have any objective data for valuing the incremental work associated with performing multiple surgeries." Unfortunately, Mr. Chairman, we don't have tomes of numbers to present to you today, either. We do, however, have hands-on experience and know that the intraoperative work expended, in this example on the fourth procedure, is not 90 percent less than that expended on the first procedure. Quite frankly, at 1 or 2 o'clock in the morning, the last procedure even seems to be a bit more, both to the surgeon and to the family waiting in the waiting room.

Finally, Mr. Chairman, a word, if I may, about payment to new doctors. Last month, my daughter, Beth, graduated from medical school. We are proud of her, of course, and I truly believe she will be a productive physician.

Chairman STARK. She is hanging on your every word.

Dr. STANLEY. She will do so even more in a moment, I am afraid. She works hard, and she does care about people. I do worry about her, though, and not just because I do have some little bit of concern about her being buried in paperwork. She owes nearly $30,000. And I understand, and you have heard from previous testimony today, that about 81 percent of such graduates now owe over $42,000, and 29 percent more than $50,000. She may very well choose a nonprimary care specialty because her interest and training so far have been in the treatment of cancer patients. But, Mr. Chairman, simplistically stated, the cost to the young physician is high, and the services of that physician to the Medicare program are at least equal to those of graying and aging doctors such as myself. It seems evident that payment should be equal.

So, in summary, again, we would urge that you bring us a realistic and truly budget-neutral conversion factor. Please help us to develop an administratively workable payment period. In this new age of Medicare payment according to resource inputs, we urge that the Health Care Financing Administration determine what those resource inputs are in the cases of the multiply injured patient, for example, and in the case of the new doctor, and be fair.

Thank you very much. I will be happy to answer questions.

[The prepared statement follows:]

TESTIMONY OF RUFUS F. STANLEY, JR., M.D.
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Congressman Stark, Subcommittee members, staff and guests, I am Rufus F. Stanley, Jr., MD, chairman of the Committee on Health Care Financing of the American Academy of Orthopaedic Surgeons. I am also a full-time practicing orthopaedic surgeon in Houston, Texas.

The Academy is comprised of over 14,000 fellows, all of whom are Board certified orthopaedic surgeons. In addition to providing continuing medical education courses for its fellows, the Academy communicates the concerns of orthopaedic surgeons about basic and clinical research, quality of orthopaedic care, and socioeconomic issues affecting the quality and access to care and the daily practice of orthopaedic surgery.

The Academy wishes to comment on the June 5, 1991 Notice of Proposed Rule Making (NPRM) for Medicare Physician Payment Reform. We would like to discuss with you aspects of the proposed rule that concern medicine in general and orthopaedic surgery in particular. We hope that you will join our efforts to convince HCFA that certain changes are needed before these proposed rules become final payment policy.

Issue: the conversion factor

The conversion factor (CF) is the multiplier that transforms relative values into payment amounts. The CF is a single national value that must apply to all services paid under the fee schedule. The conversion factor proposed in the June 5 NPRM is 16 percent lower in the schedule's initial conversion factor than we believe is justified.

We believe the conversion factor proposed in the June 5 NRPM is based on faulty assumptions; your intervention is needed to prevent an unwarranted reduction in the conversion factor.

The proposed 16 percent cut in the conversion factor goes far beyond budget neutrality, which was a clearly stated principle approved by Congress when the RBRVS process was undertaken. We believe it threatens to undermine physician payment reform before it is implemented. Projected increases for primary care and rural services will be scaled back or reversed, contrary to Congress' intent. Projected reductions for surgical services and other procedures will be magnified to the point where Medicare payment for some physicians will be lower than Medicaid rates. We already have an access problem with the Medicaid program caused in large part by unreasonable payment rates. We believe drastic cuts in Medicare payments will threaten the elderly population's continued access to physician services.

There are three elements to the conversion factor problem:

1. The NPRM includes a "behavioral" (volume) offset despite the fact that HCFA-sponsored research has failed to prove this theory. The Medicare Volume Performance Standard (MVPS) is already in place to adjust physician payments as a result of volume increases. Applying a behavioral offset is redundant and unduly punitive.

2. HCFA maintains that any adjustments in physician payment to maintain budget neutrality must be applied just to the conversion factor. This creates a "tripling effect." For every 1 percent adjustment, the conversion factor must be reduced 3 percent because in 1992 the conversion factor represents only a third of the total Medicare payment. The tripling effect can be addressed by amending the statute to require that any adjustments be applied to the historical payment as well as the conversion factor.

3. Ambiguities in the 1992 transition formula have produced estimates by HCFA that the conversion factor must be reduced to maintain budget neutrality. This problem is due in large part to the fact that payments for services being increased will change at a rate faster than for services to be reduced.

We are well-aware of how organized medicine has struggled with the notion of "fair" payment reform. One thing that has helped the profession accept Medicare payment reform was assurance from the Physician Payment Review Commission (PPRC) and Congress that reform would be implemented in a fair and reasonable manner, and would not be used to make budget cuts. Yet, that is precisely what has happened.

Together with the American Medical Association and others in organized medicine, we urge you to direct HCFA to restore the conversion factor to its intended level.

In addition to our concern about the proposed conversion factor, we have several other concerns about proposed elements of the fee schedule that will affect orthopaedic surgery. Among these concerns are the following:

- definition of the global service package
- adjustments to fee schedule payments for
  - bilateral and multiple procedures
  - site of service
  - "new" physicians

Issue: definition of global service package

The proposed global service package would include the following: preoperative visits within 30 days prior to the operation, (excluding the initial evaluation/consultation visit with the surgeon, which is paid separately), intra-operative services, and 90 days of post-operative care.

We are troubled by the global service package proposed by HCFA, particularly the inclusion of 30 days pre-operative care in the package. We believe the global service package proposed by PPRC, which includes one pre-operative visit in the global package, would be easier to implement. Additional documentation and monitoring would be needed to keep track of the 30 days of care prior to surgery, as well as the exceptions to the rule, increasing administrative costs and unnecessarily burdening physicians.

We are also concerned about the proposed way of handling reoperations related to complications. These reoperations are not a usual and necessary part of the original operation. They usually occur as a result of factors which go beyond the original indications for operation. When they occur they involve substantial additional work which should be recognized separately from the global package for the primary operation. HCFA's proposal to reimburse these reoperations at 50 percent of the primary operation makes sense conceptually, since the the pre- and post-operative care are concurrent, but we question whether the 50 percent figure represents the true resource inputs for the second procedure. We fear that unrealistically low payments for these complex cases will provide disincentives to treating Medicare patients for those surgeons whose caseloads are comprised of the most difficult cases, many referred to them by other surgeons.

We agree with the recommended 90-day post-operative period for the global service package. We believe that 90 days or less is adequate recovery time for all orthopaedic procedures in the absence of complications and that a greater than 90-day post-operative period, at least in orthopaedics, would be unwarranted. We think having a standard post-operative period for all procedures will ease implementation and be easier to administer.

Issue: adjustments to fee schedule payments

The NPRM states: Payments under the physician fee schedule are designed to reflect the resource inputs used by a physician to furnish a service. Measurements of these resources are incorporated into RVUs that are the basis for determining the Medicare fee. The relative value is comprised of work, practice expense, and malpractice costs components.

HCFA proposes several adjustments to that general approach to address specific issues within the fee schedule. Each of these adjustments is a departure from the resource-based approach; each of these adjustments seems to be justified on the grounds that it will provide incentives to physicians to change certain behaviors, or will result in additional savings to the Medicare program.

payment for multiple and bilateral procedures

HCFA proposes to pay for multiple operations by the same surgeon by paying 100 percent of the global fee for the highest value procedure only, 50 percent of the global fee for the second most expensive procedure, 20 percent for the third, and 10 percent for each succeeding procedure.

If several surgeons each perform distinctly different unrelated procedures on the same patient on the same day, each physician would be paid for the surgery performed, as in multiple trauma. (Each surgeon would be reimbursed for his procedures on the sliding scale, however.)

We question this proposed approach. To remain consistent with the resource-based fee schedule, we believe that payment for each additional procedure should be based on resource inputs, not on arbitrary percentages. Especially in cases of multiple fractures resulting from trauma, we do not believe that the fourth fracture treated, for example, requires only 10 percent of the effort of treating the first fracture.

HCFA also proposes to continue paying 150% of the global fee for bilateral procedures.

This proposal has the same limitation noted above; we would prefer to see HCFA work toward assessing the true intraoperative relative work values on a procedure-by-procedure basis.

payment differentials by site of service

HCFA proposes a 50 percent limit on the practice expense part of the relative value unit when office-based services are performed in an outpatient department. This is based on the assumption that physicians do not incur the direct costs of furnishing a service in this instance. This limit would apply to a nationally developed list of services that could be safely performed in an office setting.

While we agree that using resource-inputs is appropriate in determining fee levels, we fear that arbitrarily paying a lower fee for procedures performed in an outpatient or hospital setting will serve as a disincentive to selecting the appropriate surgical environment. While some procedures may be performed in an office setting more than half of the time, the other half of the time it is more suitable to the patient's needs to have the operation in an outpatient hospital setting. Office surgery is not always in the best interest of every patient having that procedure. The back-up resources available in the outpatient setting may be necessary safeguards required by the severity of some patients' conditions. We believe site decisions should be made by the physician, based on quality of care considerations, not by government list-makers, based on cost considerations. We hope Congress is as concerned as we are about this issue.

payment to "new" physicians

Current law requires reduced payments to "new physicians" for the first four years of their practice. HCFA proposes to reduce payment to 80 percent of the fee schedule amount in the physician's first year of practice, 85 percent in the second year, 90 percent in the third year and 95 percent in the fourth year.

We wish to express our very real dismay about this law, and request you to reconsider. We believe no good argument can be made for this discriminatory practice, since the "relative work values" of these physicians are the same as for physicians already in practice. Also, their practice expenses are at least as great, if not higher than more established physicians, due to the staggering debt incurred in financing their education.

In summary:

We urge you to support medicine's effort to return physician payment reform to the budget neutral basis that Congress originally intended, by restoring the full value of the conversion factor.. Addressing this problem is essential to preserving access and physician support for the Medicare program.

In addition, we urge you to request HCFA to reconsider its recommendations on the following topics:

- the definition of the global service package
- the fee schedule adjustments for:
    - multiple and bilateral procedures
    - site of service differentials
    - payments to new physicians

We believe changes are needed before these proposed rules become final payment policy.

Chairman STARK. Dr. Bennett.

STATEMENT OF ALAN H. BENNETT, M.D., MEMBER, SOCIOECONOMIC COMMITTEE, AMERICAN UROLOGICAL ASSOCIATION

Dr. BENNETT. Thank you. My name is Alan Bennett. I am not a member of the board of regents, but I am a member of the socioeconomic committee of the American Urological Association. I practice in upstate New York, in Albany, where I am chairman of the division of urology at the medical school.

From our written testimony, you are aware that the American Urological Association has several concerns about the proposed Medicare fee schedule. I would like to emphasize a few points. We believe, however, that most of these issues can be resolved with HCFA, and this subcommittee's continuing oversight can facilitate that process.

AUA has cooperated with all phases of the development of the resource-based relative value scale. I presented a plan 4 years ago to collapse all urology codes into five open categories, three endoscopic, two office, and two urodynamic categories, and shared this information with Bill Hsiao at Harvard. The magnitude estimation process used in phase III of the RBRVS study is quite similar to that used to develop the simplified urology coding system which has been published in our literature. Also, in our statement for the record, we have discussed other activities in this area. Thus, AUA has been proactive and interested in the concept of fair and appropriate value for services rendered by physicians.

AUA feels that the behavioral offset of 3 percent, which translates to 10.5 percent in the conversion factor, is unjustified. Medical volume performance standards should eliminate the need for a behavioral offset. As you know, transurethral resection of the prostate is one of the targeted and over-valued procedures. For several years there have been no Medicare Economic Index updates for TURP, and the fee itself has been reduced considerably. BMED data actually show a small decrease in the numbers of TUR's during this time. AUA is currently funding outcomes research to compare TURP with nonsurgical therapies. Our efforts in this area can hardly be linked to a profit motive.

The proposed conversion factor actually reduces fees for some evaluation and management services such that the basic underlying reason for RBRVS which was to compensate fairly for "cognitive" services is nullified for many physicians. For example, in the proposed new fee schedule, a level I office visit in Manhattan pays $12.36, in Utah under $10. A moderately extensive office evaluation compensates a physician $54 in New York and $46 in Utah. I cannot see a lawyer for twice that amount for a comparable amount of time.

I worked nearly 5 years on the Hsiao study through all phases. AUA has commented on each aspect of the development of RBRVS, and we were satisfied with the final Hsiao product. Yet when the proposed Medicare fee schedule was published, we saw major discrepancies, between 5 and 8 percent, in values for work and practice expense which we do not understand.

On Saturday I received a phone call from a urologist in Portsmouth, N.H., who told me that his new malpractice bill was up 20 percent, or $40,000, for the next year. I quickly looked at the Federal Register and saw that there was a 0.62 next to the malpractice rate for New Hampshire. In upstate New York, it is 0.96. Now, my malpractice is less than this doctor's malpractice. So I am questioning the malpractice figures in the Federal Register. I would also like to mention that those figures came from 1985–86 data. They are not current policies but claims made, and I think that the history of malpractice in the last few years has changed dramatically such that using 1985–86 data may not be accurate.

An issue that relates to the global service policy of——

Chairman STARK. If I could interject here. It was the intention the committee to take into account the differences in malpractice insurance costs and basically leave you whole. In other words, office expense, malpractice insurance costs, and any other adjustments would just be on the professional part of the fee. Now, if we are not doing that——

Dr. BENNETT. Well, I took that at face value also. When he called me, I looked at the Federal Register, and all I was comparing was upper New York State with New Hampshire. There is a major difference there, and I know my rate is lower than his.

Chairman STARK. OK. It could come from office expense, which is also supposed to be held harmless. But that is something we would look into. It was our intention when we wrote the law to see that you would be.

Dr. BENNETT. I understand.

An issue that relates to the global service policy of the proposed Medicare fee schedule is also troubling. Many patients require preoperative stabilization which AUA feels should not be included in the surgical globe. An example would be a patient with a stone partially blocking a kidney who is scheduled for elective surgery. Five days before the procedure the patient develops a high fever and a worsening of his pain. The kidney is now totally blocked, and the patient requires admission, 5 days of intravenous antibiotics, and a drainage procedure before the stone can actually be removed. This is not an uncommon situation.

All of this management is performed by the urologist. Under the proposed Medicare fee schedule, this care would be excluded from the surgical globe only after documentation is presented to the carrier. This presents a complicated and added burden to the physician's billing process, and it is unclear how the particular cases will be resolved. HCFA needs to make this clear in the rulemaking.

Similarly, there are many situations in urology that require a postoperative procedure within the 90-day globe. An example is a patient who has a bladder tumor removed who requires antineoplastic agents instilled into the bladder every 2 weeks and a cystoscopy and biopsy at 6 weeks. The intent of the RBRVS for TUR bladder tumor was not to include these routine and important follow-up procedures. AUA has a list of starred procedures which we feel should not be included in the surgical globe, and a copy is attached to our statement for the record.

Mr. Chairman, AUA is pleased to be represented here today and present our concerns about the proposed Medicare fee schedule. We

are truly interested in a compensation system that will allow equal access to care for all and at the same time an equitable fee structure for all physicians.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF ALAN H. BENNETT, M.D., AMERICAN UROLOGICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee:
My name is Alan H. Bennett, M.D. I am Head of the Division of Urological Surgery and Vice Chairman of the Department of Surgery at Albany Medical College in New York. I am also a member of the Socioeconomic Committee of the American Urological Association (AUA). I am pleased to present the AUA's views on the proposed rules to implement the new Medicare fee schedule issued by the Health Care Financing Administration (HCFA) on June 5.

Since 1987 I have been one of the AUA's technical advisors to the Harvard study developing relative values for physician work. As physician payment revisions have been considered, the AUA has worked with Congress, the technical group at Harvard, the Physician Payment Review Commission (PPRC), and the Health Care Financing Administration (HCFA) as these organizations fulfilled their responsibilities in the development of a new Medicare physician payment system. Despite these efforts, and those of other medical societies, many critical issues are not yet settled, even though we are only six months away from implementation of the new fee schedule. Final decisions on service definitions, relative values and even the conversion factor need to be made. The AUA believes that more time needs to be given to the complex tasks Congress assigned HCFA.

We recommend that Congress push back the effective date to allow a more orderly transition. We believe that it is in the best interests of all parties to have some more time to make sure the fee schedule goes into place with as little disruption as possible. This is essential for those medical specialties, such as geriatrics and urology, that treat a large proportion of elderly patients. These "Medicare intense" medical specialties will be highly dependent on the proper management of the new fee schedule.

Let me discuss briefly some of the activities undertaken by the AUA in furtherance of physician payment revision, cost containment, and good urologic care. I want the Subcommittee to understand the commitment the AUA has made to try to be an effective participant in the debate over health care policy. As noted, I have been a technical consultant to Dr. Hsiao and his research staff. Other urologists have joined me in this effort, and we have devoted substantial time and energy, entirely uncompensated, to try to make this process work as well as it possibly can. In addition, the AUA has been a leader in the development of guidelines for urologic services, acting both independently and in conjunction with the Agency for Health Care Policy and Research. We believe that these guidelines, when developed and implemented by physicians, will serve not only useful cost containment functions but, more importantly, will also contribute significantly to better care for patients with urologic diseases. We have joined with Dr. John Wennberg and his colleagues at Dartmouth to put together a major prospective study looking at the outcomes of different treatments for benign prostatic hyperplasia (BPH). If the Agency for Health Care Policy and Research funds this study (the AUA is currently funding the pilot study), this will be a major outcomes research effort which could have a tremendous effect on how this very common but serious condition is treated among elderly men. The current surgical treatment for BPH is a major cost to Medicare, so this study has major implications for Medicare spending as well as the quality of care provided to beneficiaries. In addition, AUA representatives have worked closely with PPRC in its many activities designed to refine and improve the fee schedule process. Finally, the AUA is developing a socioeconomic monitoring system to track the implementation of the new fee schedule, and other changes in health care, to determine their impact on urological care. We will work with the Gallup organization and use their polling experience to develop accurate feedback which can then be translated into effective policy recommendations to Congress and other branches of government.

CONVERSION FACTOR

The AUA echoes the concerns expressed by other medical societies about the reductions in the fee schedule conversion factor. The assumptions that HCFA has made about the conversion factor will have a negative impact on the reimbursement of urological services, well in excess of anticipated results. We are disappointed that HCFA has chosen a behavioral offset of such magnitude. For surgeons such an offset is almost totally unfounded. The ability of a surgeon to increase the volume of surgery is very constrained by the utilization and peer review processes that exist at many levels in Medicare. Frankly, I cannot imagine a surgeon being able to "game the system" by increasing surgical volume for very long without being called to task. In addition, Congress enacted the Medicare Volume Performance Standard (MVPS) to set targets for physician payment outlays in anticipation of possible volume outcomes for the fee schedule. With those mechanisms in place, the AUA does not understand why HCFA finds it necessary to reduce the conversion factor to this extent. It appears to us as if it is simply "budget politics" unrelated to, and inconsistent with, the goals of the new Medicare physician payment system enacted by Congress in 1989.

The other aspect of the conversion factor determination which is troubling is HCFA's interpretation of the impact of the transition on budget neutrality. It is our understanding that Congress intended the transition to be asymmetrical in order to provide the benefits of the fee schedule quickly to those who would receive them and to ease the reductions in the fee schedule by spreading them out over a longer period of time. HCFA's decision to further reduce the conversion factor because of this asymmetry undermines Congress' intent in structuring the transition this way. Physicians who expected gains are not receiving them or are receiving them in substantially reduced amounts. Those physicians who knew that there were going to be some reductions in reimbursement for services are seeing them exaggerated by the assumptions of HCFA. We believe good Congressional intent has been undermined by the Administration's implementing decisions.

On both these points, we hope that Congress, HCFA, and the medical profession can come to a rapid agreement on an appropriate conversion factor designed to meet the requirements of law and budget neutrality as outlined by Congress, but one that will also achieve the goals of physician payment reform that Congress, and the medical community, intended in 1989.

SPECIFIC ISSUES FOR UROLOGY

The balance of our testimony is devoted to issues of particular concern to urology and we hope will help this Subcommittee understand that there are many other issues which need to be examined and resolved before the fee schedule can take effect.

I have been reading the material published in the Federal Register of June 5, reviewing the various tables of relative values and practice costs, and I am struck by the fact that this is not the table of relative values or the fee schedule that I worked on in those many meetings at Harvard. Many of the relative values for physician services, at least in urology, seem to have declined by 5-7%. Likewise, practice costs also seem to have gone down, further eroding the basis upon which payment is calculated. I do not understand what has happened between the time we worked on these issues at Harvard and the publication of these proposed rules on June 5. Is this another effort to squeeze further savings from the fee schedule? We urge Congress to seek answers to these questions and to press HCFA for clarification of how it developed the tables of relative values, practice costs and professional liability premiums.

Urologists are nearly unique among surgeons in that a substantial proportion of their practice takes place in an office or ambulatory setting. Thus, the evaluation and management codes are important to the urologist's practice. It is not clear how the evaluation and management code relative values are being derived. We will continue to examine these numbers, but in view of their importance to so many physicians, we urge Congress to take a very careful look at the evaluation and management code relative values.

A key issue for all surgeons, including urologists, is the definition of the surgical global policy. Traditionally, surgeons have billed for a set of services related to an operation as a package. The fee schedule requires new definitions of services to be uniformly applied across the country. This is an appropriate step, but care needs to be taken to assure that the new definitions do not incorporate care unrelated to the surgery and its immediate aftermath. The definition of a surgical bundle should facilitate payment and program administration, and not serve as one more tool to reduce the federal deficit.

For example, HCFA has proposed that pre-operative visits for a period of 30 days between the consultation to decide on surgery and the surgical event will be included in the global bundle. It is unusual for a urologist to have any such visits unless they are related to stabilizing the patient prior to surgery or some other aspect of managing the patient. For example, a patient who needs to have kidney stones removed, but who has a serious infection or an obstructed kidney, will need care prior to removal of the stone(s). This care is not assigned to some other physician. It is the responsibility of the urologist to make sure that the patient is stabilized prior to surgery. HCFA's proposal states that if these services are "documented", then they will reimburse for them. However, we are concerned that as these rules will be implemented on a day-to-day basis, payment for any care taking place within this 30 day period will be denied, because the documentation burdens will be so great or so confusing that neither physician nor Part B carrier will fully understand their obligations. While we appreciate HCFA's recognition that surgeons engage in preoperative care of the patient unrelated to the immediate surgical activity, such as stabilizing the patient with severe infection, we believe that HCFA needs to clarify the kind of documentation that is going to be required of surgeons in order to receive reimbursement. We believe it should be minimal.

In earlier meetings with HCFA on the subject of the global surgical bundle, the AUA expressed concern that chemotherapy for urologic cancer patients administered a few weeks following surgery might get caught up in the global package and not be reimbursed. We are pleased to see in the Federal Register notice that HCFA has recognized the circumstances under which the urologist may initiate chemotherapy postoperatively for a cancer patient and has decided that the chemotherapy should be separately reimbursed. A common example of this situation is a transurethral resection (TUR) to remove malignant bladder tumors. Two weeks after surgery, the urologist will begin drug therapy with BCG. Six weeks postoperatively, the urologist will perform a cystoscopy to determine if the BCG has been effective. Currently, the BCG, its administration and the cystoscopy are paid for independently of the TUR for bladder tumor. We hope that we have correctly interpreted HCFA's rulemaking intent as addressing this problem, but we need to have this important issue for urologic cancer patients clarified.

Generally, we find the definition of the global surgical bundle to be workable except for the preoperative limitations and the postoperative clarification we have already mentioned.

An important issue for urology is the treatment of the so-called "starred" procedures. These are diagnostic and minor surgical procedures that are "starred" in the CPT-4 codes because they do

not fall under the traditional global surgical billing principles. A list is attached. These procedures have little or no follow up care related to the procedure as would be the case with a major operation. We are concerned about HCFA's proposal to put these procedures into a 30 day global package. That is, no care related to the procedure would be reimbursed for 30 days after this procedure, nor would a separate visit charge be allowed the day the procedure took place. This policy does not recognize how these procedures are being used in the care of the urologic patient. They are part of the ongoing care of the patient, and their use is not an isolated event. Identifiable evaluation and management services accompany the performance of "starred" procedures, and they should be given separate recognition. Their performance is not the primary reason the urologist is caring for this patient, as is the case for larger surgical procedures. Therefore, we recommend that HCFA drop the proposal to include "starred" procedures in the global bundle. The agency should recognize that both same day office visits, as well as care following the procedure, are appropriate for separate reimbursement.

HCFA has recognized that some procedures, such as a catheterization or a cystoscopy, have supplies or "surgical trays" that are used only for one patient and then discarded. HCFA plans to reimburse these costs separately and the AUA applauds that decision. We caution that payment should be based primarily on the local market circumstances facing physicians, not just on a national average. We will also be examining other urologic procedures performed in the office to determine whether any of them have expensive, disposable supplies which should appropriately be added to this list.

The treatment of urologic cancers is an important part of the urologist's practice. As the nation ages, urologic cancers become more prevalent. For example, prostate cancer is now the second leading cause of cancer death among men and affects primarily older men. Bladder cancer is the second most common urologic neoplasm, also frequently found in the older patient, and its incidence is rising. Very often treatment for these cancers involves a surgical procedure as well as chemotherapy, as already noted. This chemotherapy is usually under the management of the urologist.

Medicare currently pays for such therapy when administered in the physician's office. However, in an effort to standardize the rules of payment for these chemotherapy services, HCFA has chosen a pricing mechanism for the drugs which may work to the disadvantage of both urologists and their patients. HCFA proposes to pay for all covered outpatient drugs, as well as chemotherapy, on the basis of average wholesale price less 15%. The assumption by HCFA is that physicians can obtain the same discounts that are available to hospitals and pharmacies. This may be true in certain parts of the country, but I can assure you it is by no means universal. In fact, in our practice in Albany we pay nearly a full retail rate for these drugs, and our costs would be even higher if we purchased them through our hospital. The ability of a physician to command a discount depends on the competition in the local marketplace, the distance from sources of supply, and whether or not the drug is a multisource or single source drug, along with many other market factors. For this reason, development of a universal discount policy for payment of these products simply will not work.

Mr. Chairman, the AUA recognizes that the payment decisions affecting drugs, particularly chemotherapy, are complex. A decision that works well in one region or for one set of drugs may not work well in a different region or for a different set of products. We hope that HCFA is open to modifications of these proposed policies, particularly chemotherapy, which is so vital yet so expensive. We trust that a payment mechanism can be developed that is more responsive to those local market circumstances over

which the physician has little or no control. Chemotherapy for cancer patients should not be seen as just another source of budget savings at the expense of the patient.

Likewise HCFA has proposed to eliminate payment for the injection of certain kinds of chemotherapy when an office visit is billed. We need to have this issue reexamined as well since the office visit is a very important part of evaluating the total health of the cancer patient, and is performed for a broader purpose than the administration of therapy. The payment for the injection covers the additional specialized costs related to chemotherapy and should also be recognized.

Urologists regularly use several imaging procedures, such as transrectal ultrasound, in their offices. The AUA is concerned that these relative values come entirely from the radiology fee schedule with no input from urology. We have identified invasive imaging procedures in the radiology fee schedule which are performed primarily by urologists and seem to be undervalued in some cases and overvalued in others. We ask that this situation be corrected. Perhaps Dr. Hsiao could revisit imaging services and obtain input from other physicians through a specialty panel process. Transrectal ultrasound needs special consideration, in addition. Although the equipment is expensive, it is invaluable to the urologist and has rapidly become the standard of care in urology office practice. It is essential to proper performance of the prostate biopsy and its use is expanding in urology. We will be making specific recommendations to HCFA on the reimbursement of such essential, yet capital intensive, services.

Let me conclude by noting two issues in the fee schedule that only Congress can address. The first is the Medicare payment rules for new physicians. The budget driven reductions to the payment in the first four years of practice enacted in 1990 are very unfair to new practitioners. We urge you to change this law.

The second issue relates to payment for the assistant surgeon. Last year Congress reduced this payment from 20% to 16% of the primary surgeon's fee. This is too low. It will make it increasingly difficult for surgeons in community hospitals to get competent assistants for complex operations. There are other steps which Medicare can take to deal with instances of the improper use of assistant surgeons that do not require payment cuts. Last year's decision is going to make a difficult situation much worse in many communities. The AUA urges Congress to restore payment for the assistant surgeon to previous levels.

Mr. Chairman, the development of the resource based relative value scale and the new Medicare fee schedule has been a difficult path for all parties. It is the hope of the American Urological Association that you share our desire to see this process go forward with the least possible disruption of care to the Medicare patients. We believe the particular issues key to urology are important ones whose resolution can have an impact on the type and quality of urologic services that will be available in the future to Medicare beneficiaries. We hope you will urge HCFA to be responsive not only to the concerns we are raising, but also to the other specific issues raised by other physicians. We particularly hope that we will be able to work with HCFA in the restoration of the conversion factor. As the AUA prepares its comments to HCFA on the proposed rules, we will make specific, corrective recommendations wherever possible that will go beyond today's discussion of the issues. The AUA's task force on the fee schedule, on which I sit, will be discussing these options very soon.

This concludes the AUA's formal statement, and I would be happy to respond to any questions the Subcommittee may have.

AMERICAN UROLOGICAL ASSOCIATION

Recommended Starred Procedures
Urological Section CPT

GROUP #1: This procedure is a diagnostic procedure. It specifically involves using an instrument to visualize a specific organ or cavity. It is not therapeutic nor meant to be. After the procedure is performed a treatment or further diagnostic plans are put forward. A biopsy may be performed if indicated by the findings.

Existing Starred Procedures:

CPT Code	Descriptor

Recommended Additions For Same Reason:

CPT Code	Descriptor
44380	Fiberoptic ileoscopy through stoma
50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50553	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50559	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50578	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration

50951 Ureteral endoscopy through established ureterostomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service

50953 Ureteral endoscopy through established ureterostomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization

50955 Ureteral endoscopy through established ureterostomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy .

50957 Ureteral endoscopy through established ureterostomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy

50959 Ureteral endoscopy through established ureterostomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration (not including provision of material)

50970 Ureteral endoscopy through ureterotomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service

50972 Ureteral endoscopy through ureterotomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization

50974 Ureteral endoscopy through ureterotomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy

50976 Ureteral endoscopy through ureterotomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy

50978 Ureteral endoscopy through ureterotomy with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service, with insertion of radioactive substance with or without biopsy and/or fulguration (not including provision of materials)

52000 Cystourethroscopy (separate procedure)

52005 Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service

52007 Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive service with brush biopsy of ureter and/or renal pelvis

52010 Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

52204 Cystourethroscopy, with biopsy

52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

52224 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

52250	Cystourethroscopy, with insertion of radioactive substance, with or without biopsy or fulguration
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
52285	Cystourethroscopy, for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	Cystourethroscopy, with urethral meatotomy, unilateral or bilateral
52310	Cystourethroscopy, with removal of foreign body, calculus or ureteral stent from urethra or bladder (separate procedure); simple
52335	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method)

AMERICAN UROLOGICAL ASSOCIATION

Recommended Starred Procedures
Urological Section CPT

GROUP #2: This is biopsy performed for diagnostic purposes. It does not usually require any specific intervention to manage any post procedure difficulties.

Existing Starred Procedures:

CPT Code	Descriptor
50200	Renal biopsy; Percutaneous, by trocar or needle

Recommended Additions For Same Reason:

CPT Code	Descriptor
53200	Biopsy of urethra
54800	Biopsy of epididymis, needle
55700	Biopsy, prostate; needle or punch, single or multiple, any approach

GROUP #3: This is a diagnostic insertion of a needle in to a cyst or body cavity. It is not therapeutic and the underlying disease will be treated based on the results of this test.

Existing Starred Procedures:

CPT Code	Descriptor
50390	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
51000	Aspiration of bladder by needle
55000	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication

Recommended Additions For Same Reason:

CPT Code	Descriptor
54230	Injection procedure for corpora cavernosography
54235	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine, etc.)
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

GROUP #4: This is a diagnostic test performed to evaluate the function of a portion of the urinary collection system. It evaluates the function of the renal pelvis, ureter, bladder, urethra or sphincters of the urinary system.

Existing Starred Procedures:

CPT Code	Descriptor

Recommended Additions For Same Reason:

CPT Code	Descriptor
50396	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50686	Manometric studies through ureterostomy or indwelling ureteral catheter
51725	Simple cystometrogram (CMG) (eg, spinal manometer)
51726	Complex cystometrogram (eg, calibrated electronic equipment)
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
51739	Sound recording of external stream (eg, Lyons type, Keitzer type)
51741	Complex uroflowmetry (eg, calibrated electronic equipment)
51772	Urethral pressure profile studies (UPP) (urethral closure pressure profile); any technique
51785	Electromyography studies (EMG) of anal or urethral sphincter, any technique
51792	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)
51795	Voiding pressure studies (VP); bladder voiding pressure; any technique
51797	Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)

GROUP #5: This procedure involves the percutaneous insertion of a catheter into a body cavity or a portion of the urinary drainage system. It does not address the underlying condition of the patient. It treats the symptom. The patient will continue to require treatment of the underlying clinical problem.

Existing Starred Procedures:

CPT Code	Descriptor

Recommended Additions For Same Reason:

CPT Code	Descriptor
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous

GROUP #6: This involves irrigating a portion of the urinary system. It may involve the use of special irrigating fluids including anticarcinogens. Associated care of the patient is entirely dependent on the underlying clinical condition.

Existing Starred Procedures:

CPT Code	Descriptor
51700	Bladder irrigation, simple, lavage and/or instillation

Recommended Additions For Same Reason:

CPT Code	Descriptor
51720	Bladder instillation of anticarcinogenic agent (including detention time)

GROUP #7: This procedure involves the injection of dye into a cavity, or portion of the collecting system.

Existing Starred Procedures:

CPT Code	Descriptor
51600	Injection procedure for cystography or voiding urethrocystography

Recommended Additions For Same Reason:

CPT Code	Descriptor
50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)
50684	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter (separate procedure)
50690	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure)
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	Injection procedure for retrograde urethrocystography
52283	Cystourethroscopy with steroid injection into stricture

GROUP #8: This is an access procedure

Existing Starred Procedures:

CPT Code	Descriptor
50398	Change of nephrostomy or pyelostomy tube
50688	Change of ureterostomy tube
51005	Aspiration of bladder by trocar or intracatheter
51705	Change of cystostomy tube; simple
51710	Change of cystostomy tube; complicated
53600	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent
53620	Dilation of urethral stricture by passage of filiform and follower, male; initial
53621	Dilation of urethral stricture by passage of filiform and follower, male; subsequent
53640	Passage of filiform and follower for acute vesical retention, male
53670	Catheterization, urethra; simple
53675	Catheterization, urethra; complicated (may include difficult removal of balloon catheter)

Recommended Additions For Same Reason:

CPT Code	Descriptor
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
51010	Aspiration of bladder with insertion of suprapubic catheter
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
53000	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53605	Dilation of urethral stricture or vesical neck by passage of sound or urethra dilator, male, general or conduction (spinal) anesthesia
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral

GROUP #9: These procedures usually require short term (7-10) days follow-up for the effects of the procedure. The patient may or may not require care of other problems concurrently.

Existing Starred Procedures:

CPT Code	Descriptor

Recommended Additions For Same Reason:

CPT Code	Descriptor
53260	Excision or fulguration; urethral polyp(s), distal urethra
53265	Excision or fulguration; urethral caruncle
53270	Excision or fulguration; Skene's glands
53275	Excision or fulguration; urethral prolapse
54160	Circumcision, surgical excision other than clamp or dorsal slit; newborn
54220	Irrigation of corpora cavernosa for priapism
54505	Biopsy of testis, incisional (separate procedure); unilateral
54506	Biopsy of testis, incisional (separate procedure); bilateral
54620	Fixation of contralateral testis (separate procedure)

GROUP #10: These procedures are drainage of an abscess or other pocket of fluid. The concurrent care as required within the 7 day follow-up.

Existing Starred Procedures:

CPT Code	Descriptor
55100	Drainage of scrotal wall abscess

Recommended Additions For Same Reason:

CPT Code	Descriptor
53040	Drainage of deep periurethral abscess
53060	Drainage of Skene's gland abscess or cyst
53080	Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085	Drainage of perineal urinary extravasation, complicated
54015	Incision and drainage of penis, deep
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)

GROUP #11: This is a procedure which does not usually require additional follow-up care.

Existing Starred Procedures:

CPT Code	Descriptor
53660	Dilation of female urethra including suppository and/or instillation; initial
53661	Dilation of female urethra including suppository and/or instillation; subsequent
54050	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54055	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation
54200	Injection procedure for Peyronie disease

Recommended Additions For Same Reason:

CPT Code	Descriptor
53020	Meatotomy, cutting of meatus (separate procedure); except infant
53025	Meatotomy, cutting of meatus (separate procedure); infant
53665	Dilation of female urethra, general or conduction (spinal) anesthesia
54000	Slitting of prepuce, dorsal or lateral (separate procedure); newborn
54001	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn
54056	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple cryosurgery
54057	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
54060	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
54100	Biopsy of penis, cutaneous (separate procedure)

54105	Biopsy of penis, deep structures
54150	Circumcision, clamp procedure; newborn
54152	Circumcision, clamp procedure; except newborn
54240	Penile plethysmography
54250	Nocturnal penile tumescence test
54450	Foreskin manipulation including lysis of preputial adhesions and stretching
54500	Biopsy of testis, needle (separate procedure)
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

GROUP #12: This procedure is performed on a cadaver and there is no postoperative management.

Existing Starred Procedures:

CPT Code	Descriptor

Recommended Additions For Same Reason:

CPT Code	Descriptor
50300	Donor nephrectomy, with preparation and maintenance of homograft; from cadaver donor; unilateral or bilateral

Chairman STARK. Thank you, Dr. Bennett.

Dr. Jamplis, you may proceed.

STATEMENT OF ROBERT W. JAMPLIS, M.D., PRESIDENT, SOCIETY OF THORACIC SURGEONS

Dr. JAMPLIS. Mr. Chairman and members of the committee——

Chairman STARK. Did you know Paul Samson?

Dr. JAMPLIS. Pardon?

Chairman STARK. Did you know Paul Samson, who practiced over in the East Bay?

Dr. JAMPLIS. Paul Samson? Do I know Paul Samson and Dave Dugan? Absolutely. They were my mentors and teachers.

Chairman STARK. He was my neighbor for many, many years.

Dr. JAMPLIS. And a great guy, one of the best.

Chairman STARK. A great guy, yes.

Dr. JAMPLIS. I am Dr. Robert Jamplis, and I am a cardiothoracic surgeon at the Palo Alto Clinic in California and I represent all of the cardiothoracic and vascular organizations of the United States as the president of the Society of Thoracic Surgeons this year.

I have submitted my written testimony so I would like to confine my oral remarks to just 10 very short and succinctly stated points.

Number one, we believe that only the most accurate data be used to develop the Medicare fee schedule. And I don't think anybody would disagree with that; we're talking about accuracy.

Number two, there are gross inaccuracies in the Harvard researcher's data. Number three, at the very beginning the Thoracic Society wished to participate constructively and responsibly rather than just be nay sayers. Number four, therefore we pursued the option of doing another independent study using one of the firms, Abt Associates from Cambridge, Mass., which were suggested to us by HCFA and by the PPRC. They used the same methodology that the Harvard researchers used so that we could compare apples to apples, although we have some reservations about the validity of the methodology.

Number five, it was an arms-length operation. We did finance the study but that is all. We chose Abt from a group of two or three recommended by PPRC and HCFA and they went about their business independently and with an oversight committee of three very responsible people led by Dr. Al Dobson.

Number six, the study was done last fall and the PPRC and HCFA, as well as the Harvard researchers now have the data. We wanted only the best available accurate data and we believe that we got it.

Number seven, the Abt results, we firmly believe, are more accurate than the Harvard I, II or III. Number eight, we have also conducted a review of values in the NPRM, just recently put out by HCFA and we believe that at least one-third of those values are wrong.

Number nine, in addition, many of the important thoracic surgery codes are completely missing from the NPRM altogether. And finally, number 10 and this is probably the most important of all, we believe that the inaccuracies and omissions can be corrected very simply by using the Abt restudy figures.

So, Mr. Chairman and members of the committee, we ask only that the correct data be used by HCFA before the final relative values for cardiothoracic and vascular services are cast in concrete, even if this means delaying the January 1, 1992 date.

Thank you.

[The prepared statement follows:]

Statement of

The Society of Thoracic Surgeons

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

on

Medicare Payments to Physicians Under the Resource-Based Relative Value Scale

presented by

Robert W. Jamplis, M.D.
June 25, 1991

Mr. Chairman and Members of the Subcommittee, my name is Robert W. Jamplis, M.D. I am a practicing cardiothoracic surgeon in Palo Alto, California, and also have the privilege of serving as the current President of The Society of Thoracic Surgeons (STS). I am pleased to present the views of the Society, and of the other major thoracic surgical organizations in the United States, about the Government's recently proposed rules regarding physician payment reform.

As you know, the notice of proposed rulemaking (NPRM) issued by the Health Care Financing Administration (HCFA) outlines a very extensive and complex set of changes that will govern Medicare physician payment policies in major new ways. The Society has been a very active participant in recent years in working with HCFA and with the Physician Payment Review Commission (PPRC) to design some of the elements of the proposed rule and to achieve a reasonable implementation of the new payment reform plan. We intend to continue in this role.

We also fully expect to submit our views in detail before the comment period closes about such issues as: the proposed definitions for global surgical services, coding changes, the conversion factor, payments for and the use of assistants-at-surgery, and other matters.

At this stage of our analysis, however, we wish to focus the Subcommittee's attention on the very critical issue of how to best assure that the most accurate data possible will be used by HCFA to establish the final relative values for cardiothoracic and vascular services provided to Medicare patients under the new fee schedule.

The Society found that there were, and still are, important inaccuracies in the data originally gathered by the Harvard researchers in developing relative values for some physicians' services, including those applicable to our specialty. Because of these concerns, the Society consulted at length with officials from the agency and from the PPRC about options for improving the data base for making the estimates of relative values for cardiothoracic and vascular services.

Mr. Chairman, we wanted to participate as responsibly as possible in this process, and not just be nay-sayers about the impending policy changes. As a result, we decided to pursue the option of a further independent restudy of the specialty conducted by another qualified and independent research organization (Abt Associates, Inc. of Cambridge, Massachusetts) using the same methodology for developing relative values employed in the original Harvard study. The Society financed the additional research, but had no other direct involvement in the study--as both the PPRC and

HCFA can confirm. Our goal, which we hope that the Subcommittee and HCFA share, was and is to base the fee schedule on the best available accurate data.

Last fall, the Abt restudy of our specialty was completed, and we believe that the results are much more accurate than the initial or subsequent work of the Harvard researchers regarding cardiothoracic and vascular services. These study findings have been shared with both HCFA and with the PPRC as both groups go about the task of refining the work values under the new fee schedule. In addition to the report's findings, we are sharing all of the basic underlying data gathered from the Abt restudy with the Harvard researchers, with HCFA and with the PPRC.

We were, of course, both surprised and obviously concerned that the text of the NPRM did not make mention of this very extensive research work as a potential source for refining the final relative values for our specialty in the final fee schedule. However, since the agency did recognize and mention in its initial fee schedule announcement made last fall that the restudy work for cardiothoracic and vascular procedures was underway, we presume that failure to refer to this research is merely an unfortunate oversight.

We have conducted a preliminary review of the values set out in the NPRM, and have determined that a significant number of those values--at least thirty percent of them--are still inaccurate, and that further refinements are, therefore, still much needed. Moreover, relative values for a substantial number of important cardiac surgery codes are missing from the NPRM altogether, limiting our ability to provide constructive comments about many of the services rendered by our specialty. We believe that these errors and omissions can be corrected by evaluating the data from the Abt restudy project in order to assure that the potentially serious distortions in the values for the services of our specialty are corrected before the fee schedule is implemented.

What the Abt study suggests is that the pre- and post-operative values, especially for the balance of the intraoperative work period, are wrong as constructed by the Harvard study. We have looked very carefully at the resulting relative value units in the NPRM and they simply do not pass face validity. When one compares the work value of one of our procedures with another, we find that approximately thirty percent are incorrect. This means that the results from the Harvard phase III project are likely to be inaccurate as well. We strongly feel that HCFA has to correct this situation by directly measuring the work involved, and by adjusting the relative value units accordingly--because the measurement of work is what we're talking about.

Thus, we continue to believe that the results of the Abt restudy should be used by HCFA as the basis for setting the intraspecialty values for the specialty because they are more valid, reliable and fill virtually all of the data gaps that are yet to be filled in the final announcement. We understand that HCFA has asked the Harvard researchers to comment on the restudy, so that the agency can take our independent study as well as the Harvard team comments into consideration in setting final values for cardiothoracic services and vascular.

Mr. Chairman, we would appreciate the Subcommittee's support to assure that an objective evaluation of all of the data--including the Abt restudy results--is completed before determining the final relative values for cardiothoracic and vascular services under the new Medicare fee schedule.

Thank you.

Chairman STARK. Thank you, Dr. Jamplis.

Some of what you are suggesting is too technical for the Chair. I suspect that only Dr. McDermott understands the detail of your statements. Are you all comfortable with the procedure that the committee generally uses in deferring issues that are technical and relate to the professional procedures and costs in our being advised by PhysPRC? Have you all felt that we are well advised, and are you comfortable when we turn it in?

Are there any of you who feel that you are not well represented by PhysPRC and if so, what balance could we suggest to that? Because they basically are our advisers. I have tried to keep the committee from making a determination as to whether your procedures are worth 2 percent more than your procedure, but I'm not sure that I want to be involved professionally with either one of you. Socially, yes, but insofar as whether the relative value scales are working or are effective, that's my question.

Is there anybody here who feels that there is any unfairness or bias in the PhysPRC—Physician Payment Review Commission that we ought to correct?

Dr. BENNETT. Yes, I don't think that they have addressed the issue quite yet. I think the dynamics are set up for that. They had a meeting a couple of weeks ago at which that was supposed to be addressed but I understand that it wasn't. So I am comfortable that if they address the issue that it will be adjudicated across specialty lines. I think the mechanism is set up to do that.

I don't think it's been done yet, however.

Chairman STARK. So you are comfortable with the composition of the Commission and the way in which the committee relates to it. Anybody else?

Dr. JAMPLIS. Well, I'm comfortable with that particular fact, but what we're uncomfortable about are the actual gross values. They're so far off. And I, particularly, Mr. Chairman, didn't want to get technical, but they're almost absurd. And it's laughable almost.

So what I'm saying is if this is going to be the basis for valuation, and we don't have much to say about the geographic or the practice costs or the malpractice or the conversion values, but the thing that we do know, as doctors, is the relative value. This is why we honed in on it, and we think this Abt study must be looked at and it's not being looked at.

Chairman STARK. You are going to have to explain that to Dr. McDermott who was radically overpaid in private practice and the only way he is more overpaid is in Congress.

Mr. MCDERMOTT. Give me examples. I would like to hear what——

Dr. JAMPLIS. OK, I will give you an example. In the Harvard I, the most complicated procedure that had the most value was a simple pericardiectomy which I would let an intern do under supervision, that's an example.

Mr. MCDERMOTT. The most high value?

Dr. JAMPLIS. The highest value was given and that's been corrected in the II and III, but there are many other things. For instance, we now try to save lungs, as a lung surgeon we try to save all the lungs we can by doing what is called a sleeve resection. We

are not going to get technical about it. It's a lung saving procedure. We don't even have a code for that. We don't have a code for many procedures we perform.

We don't have anything for a redo valve which is much more difficult than when you do it primarily. And I could go on and on, because I said in my testimony, one-third, we think, of the values are incorrect, that were included by HCFA in the NPRM.

Chairman STARK. My understanding in listening to PhysPRC's testimony earlier was that they would concur with you. I'm not sure about the specific procedures, but much work needs to be done. But, you don't make those decisions.

Dr. JAMPLIS. No, I hope——

Chairman STARK. I mean I'm changing spark plugs and——

Dr. JAMPLIS. I would like Dr. Samson if he was alive to make them but not you, Mr. Chairman, no.

Chairman STARK. Well, how about in between?

Dr. JAMPLIS. All right, in between, all right.

Chairman STARK. My question is, are you comfortable dealing with PhysPRC and do you feel that you will get a fair and competent hearing there in the procedure that we've established?

Dr. JAMPLIS. With HCFA?

Chairman STARK. No, with PhysPRC, they work for us.

Dr. JAMPLIS. Absolutely.

Chairman STARK. OK, that's what I want to make sure, that's key.

Dr. JAMPLIS. Yes.

Dr. STANLEY. We have had, and still do, Mr. Chairman, several problems in our specialty regarding the basic methodology in the Harvard study, many of which we have discussed with the PPRC staff—and some commissioners—and have universally received a very open audience and they've been very helpful in hearing our concerns and in many instances making some very helpful explanations to us about the methodology.

Mr. MCDERMOTT. Can I pursue just a second the example given of the sleeve resection? Are you saying that there is no CPT code for that?

Dr. JAMPLIS. There's a code.

Mr. MCDERMOTT. There is a code but in the relative value scale they didn't include that code?

Dr. JAMPLIS. Correct, right.

Mr. MCDERMOTT. And how——

Dr. JAMPLIS. That's just one of many, so we wouldn't know how HCFA would value it.

Chairman STARK. You know how to do it. You just don't know how to get paid for it?

Dr. JAMPLIS. Exactly, exactly, that's exactly right.

I would want to say that the PPRC has been remarkably good, in our estimation, in being responsive. Of course, Phil Lee is a former partner of mine, but nevertheless, at an arms-length business, we can talk about things. And believe me, they have been fair and in our estimation, their data is more accurate than HCFA.

Dr. BENNETT. There are a couple of reasons why sleeve resection may not be listed. One, there may not have been a lot done to come up—it may have been one of the less than 5 percent procedures.

The relative value scale update process should take care of that and phase III might take care of that also. We don't know what the phase III data are.

The point about what we saw in the Federal Register still bothers me, because for 5 years I've looked at numbers through phase I, II, and III and across specialty work as well—there's no question that there is a difference in not only practice expense, but work values in several of the urology procedures, and I have looked at general surgery procedures and gynecology procedures and the numbers are different than phase II.

So I think that that needs to be looked at by somebody.

Chairman STARK. Where do you think that difference came from, from PhysPRC or HCFA?

Dr. BENNETT. I think it came from HCFA. And we commented on Phase II on one procedure that we felt was undervalued and I guess I shouldn't say this, but it went up 6 percent. That's the only one that went up 6 percent. Everything else went down 5 to 8 percent, that's all our averaging.

Chairman STARK. If it gives you any comfort, I have always considered the bean counters in the administration to know the cost of everything and the value of nothing. You can save money but it seems to me that doing it without doing great damage is pretty tricky.

Mr. MCDERMOTT. Is it fair then to assume that you are saying the squeaky wheel got the grease?

Dr. BENNETT. For one procedure, but 47 other procedures took it in the ear, and I don't think that because one procedure may have been under-valued and you brought it back to a value that a lot of other procedures were cut, that may have had fair value, I don't understand the logic in doing that.

Chairman STARK. Now, seeing as you all at this table would get the heaviest hit here, would you have less objection if we didn't make such a large adjustment in the index? But if there is, in fact—because we are basically raising the family practitioner's and the primary care guy's a lot with a lot of small numbers faster than we are bringing you down—if we made some initial larger cuts in the surgical procedure but didn't fuss with the index?

I know you don't like either, but is that less objectionable?

Dr. STANLEY. We, as you very well know, with regard to the so-called overvalued procedures, Mr. Chairman, already have——

Chairman STARK. Well, let's not say overvalued.

Dr. STANLEY [continuing]. Already have received, as the saying goes, significant hits. So I would be forced to reply that I would have to look at the numbers and look at the procedures because we are having growing concerns, as I know you can understand, about——

Chairman STARK. If we leave the volume alone—we are talking between zero and 16, or 6 and 16——

Dr. STANLEY. You are talking about unit payment?

Chairman STARK. Yes. Leave the volume alone, we will catch up with you later. I mean if you start to take out more lungs by double, we'll cut your fees in half. I can figure that one out with my shoes and socks on.

Dr. JAMPLIS. So can I and you would be justified.

Chairman STARK. But in the meantime to say if we leave the volume out then we have got really only one or two ways to keep this reimbursement package the same size. That is, we can lower that index and that lowers it for everybody, this larger percentage; or we can pick and choose on the theory that within a couple of years to your pleading your case between PhysPRC all those fees will get closer to what's fair.

Dr. STANLEY. Many of us—excuse me—many of us in the specialty societies have had a desire, now a growing desire to be more involved in the process, to look at our own procedures, to analyze what is regarded as an inappropriate increase in volume and/or decrease in unit charge to see if we feel that for purposes of care of the patients that we are taking care of individually whether those are appropriate in our mind. If, indeed, they're not, then through our collegiality peer review/one-on-one relationship can, indeed, offer some help in this.

Chairman STARK. Yes, I would like you all to get that resolved. I will argue with you about the updates some day, because that is an aggregate thing. That is what the AMA was deathly afraid of that we're going to ration stuff. But at some point, my argument with you ought to be do you go up next year 10 percent or 11? So we say 10.5, so OK, so I saved a half a point. That's a lot of money for the taxpayers. You all have to decide among yourselves how you are going to take the hit or the increase if you ever get it.

But what I'm saying is we're talking about rate of increase and in the aggregate. Now, some of you come down on fees, some guys come up—I understand that. I'm not competent to make that decision or our committee either. That is why this Hsiao just happened to come over the horizon at a time when we needed him. That wasn't an idea of this committee and so there was a way for you all to get together to figure out who is going to go up and who is going to go down.

Once we have that, and once you guys have agreed, either by as surgery and primary care—I don't much care if you divide it up, I don't much care if you want to go State by State—makes some sense to me. But then we have an aggregate amount. That's something that is a simple number that Members of Congress can see, is it 10 or 11? And we can think about what it was, and what the costs of the yen is, and what inflation is, and what income taxes are, and what malpractice is, and the hassle factor and we can say, well, you guys were good guys last year, and we will give you 11, or you were real stinkers and we are only going to give you 10 and we fight and we win or lose. But we come back to live, and take the rest of that and do it within your own peer groups and before a council of mostly your peers at PhysPRC and you are comfortable with that, that's what we're trying to get to.

Dr. JAMPLIS. Well, Mr. Chairman, I would agree with that, but the only important thing is that among ourselves we get the correct figures for the relative values. That's been my whole testimony. The Abt study must be listened to, it must be listened to by HCFA and the PhysPRC. Then we can get accurate values and then we can do what you ask.

Chairman STARK. You figure you can roll me, huh?

Dr. JAMPLIS. You are right.

Dr. STANLEY. If you all will excuse me, and if I may briefly add: Our perspective needs to include in our observations and studies the effect that we perceive the changes are having on patient care as they apply to our particular patient populations.

Chairman STARK. Good enough.

Thank you, all, very much.

Mr. MCDERMOTT [presiding]. The next panel is Dr. Betty Stephenson, president of the American Society of Anesthesiologists; Dr. James Moorefield, chairman of the board of chancellors of the American College of Radiology; and Dr. William Winters, the immediate past president of the American College of Cardiology.

We want to welcome you all here. You have been sitting a long time waiting for a chance to talk. Your entire written statements will be placed in the record, and we would like to ask you to limit yourselves to 5 minutes and then we will ask you some questions.

Dr. Stephenson.

STATEMENT OF BETTY P. STEPHENSON, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Dr. STEPHENSON. I am Dr. Betty Stephenson, president of the American Society of Anesthesiologists and I really appreciate the opportunity to appear today. I promise you it will be much less than 5 minutes since we have had a long morning.

Mr. MCDERMOTT. At least you know what we want to know.

Dr. STEPHENSON. Yes, sir.

In common with the other medical societies from which you've heard, our members are shocked at the totally unanticipated level of reductions in anesthesiologists fees proposed by HCFA. They appear to aggregate for our specialty nearly a 50-percent cut by the time the new fee schedule takes full effect. We share with all of medicine the concern with the behavioral offset and the transition formula. We have technical issues which we will work on with HCFA and PPRC.

This has been a long and technical hearing, and I appreciate the chairman's earlier remarks with regard to—he's not here now——

Mr. MCDERMOTT. He's eating soup in the back room and he will be right back out.

Dr. STEPHENSON [continuing]. Earlier remarks with regard to anesthesia volume and time. I think we can be very brief in the oral comments. HCFA has decided totally without statutory foundation to eliminate time units from the calculation of relative values for anesthesia procedures. This decision is directly at odds with OBRA 1989 which required that in establishing the fee schedule for anesthesia services, HCFA shall use, to the extent practicable, the uniform relative value guide already mandated for use by Medicare carriers.

This directive from the Congress was no accident. It was, to the contrary, the product of a very carefully developed partnership between the Congress and organized anesthesiology, designed to refine the reimbursement method for our services under Medicare, to make it as fair and accurate as possible.

In the Budget Reconciliation Act of 1987, the Congress mandated adoption of the uniform anesthesia relative value guide for use by

Medicare carriers. A critical corollary to this step was the adoption of an uncomplicated set of 250 anesthesia codes to replace the 4,200 surgical codes previously used for anesthesia reimbursement.

Inclusion of time units in the RVG has allowed for simplification to the 250 procedure descriptors that we have. For example, the anesthesia code for lower abdominal procedures covers about 160 surgical codes. Two years after OBRA 1987, following a study by the Inspector General, the Congress, with ASA's full cooperation and support, instituted the use of actual minutes for calculating RVG anesthesia time instead of HCFA's previous method of rounding up to the nearest full time unit.

When in OBRA 1989, Congress directed HCFA to utilize the uniform relative value guide, it did so with the deliberate knowledge that this guide involved time units, as well as base units. It had already mandated actual time units in that very same 1989 law.

Now, in adopting the model fee schedule, HCFA has, with no substantive justification, proposed to eliminate the separate calculation of time units, and to require use of average time. The variations in surgical time, case mix, and case load, over which we have little or no control, point to the impossibility of fairness by averaging time among anesthesiologists. We agree with the chairman that the use of average time would create more problems than would be resolved.

As the subcommittee is aware, the PPRC has already supported the retention of separate time units in reimbursement for anesthesiology services. We urge Congress, further, to reinforce its original budget-neutral mandate to HCFA that actual time units, as well as base units be included in the anesthesia portion of the Medicare fee schedule.

There's no evidence of gaming. We do not have that opportunity, but even so, ASA has provided a tighter definition of time, which has been accepted by PPRC and should be accepted by HCFA.

Thank you, very much for the opportunity to appear.

[The prepared statement follows:]

TESTIMONY OF BETTY P. STEPHENSON, M.D., AMERICAN SOCIETY OF ANESTHESIOLOGISTS

I am Betty P. Stephenson, M.D., President of the American Society of Anesthesiologists and a private practitioner from Houston, Texas. The American Society of Anesthesiologists, representing more than 27,000 physicians nationwide, appreciates the opportunity to appear before the Subcommittee today. We have many serious concerns about the recently-proposed Medicare Fee Schedule, which we believe has been developed in a punitive fashion and without regard to the legislative history of the Resource Based Relative Value Scale.

Over the past five or more years, both the Congress and the medical community have invested considerable effort and anguish as the RBRVS moved from an abstract concept to concrete legislation. Many physician organizations, including our Society, participated in this process -- in our case even with the knowledge that reimbursement to our specialty would be reduced under the RBRVS. However, other inequities would be addressed, including geographic inequities for anesthesiologists, and the idea of a relative value system for all physicians held considerable more appeal.

The participation of the medical groups, however, was largely achieved by a sense of partnership with the Congress. Compromises were made on a variety of issues, but we believe passage of the Omnibus Budget Reconciliation Act of 1989 achieved a good package and one which should have been straightforward for the Health Care Financing Administration to implement.

What we see now, however, is a proposed regulation which turns that partnership and compromise into confrontation as HCFA has produced what consumer advocates would call a "bait and switch" product. Specialty societies -- with strong assurances to our memberships that this was the right thing to do -- entered an agreement with the Congress and bought into an advertised product that now threatens to devastate many specialties and pose quality and access problems for our patients.

ASA joins with the American Medical Association and other specialty societies in calling for (1) prohibition on the use of a behavioral offset; (2) a correction to the asymmetrical transition problem; and, (3) elimination of the tripling effect of applying all adjustments to the conversion factor.

We have very specific concerns with HCFA's approach to anesthesia services, particularly the elimination of anesthesia time as a separate component of our relative value guide. We will address the proposal to eliminate anesthesia time, the problems with the conversion factor, and some of the methodological problems.

Anesthesia Time

ASA strongly opposes HCFA's proposal to eliminate separate recognition of anesthesia time under the Medicare Fee Schedule (MFS). Such an initiative is unwarranted, goes against Congressional intent, is opposed by the PPRC, and would have devastating results on the delivery of anesthesia care.

Anesthesia Payment and Development of the URVG

In order to put in context HCFA's proposal to eliminate anesthesia time, it is worthwhile to review the development of the Uniform Relative Guide (URVG) as mandated by Congress.

Anesthesiologists have been reimbursed on a relative value system -- indeed, since well before the advent of the Medicare Program. Insurers approached the ASA in the mid 1950's and suggested that some consistency be brought to the many billing methods used by anesthesiologists. This led to the development of the resource-based Relative Value Guide (RVG), which has been maintained and published by the ASA since 1962. The RVG assigns base units which measure the skill, risk and complexity of the anesthetic procedure. Base units include the value of all usual anesthesia services except the time actually spent in anesthesia care. Base units also include usual preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.) The base units are combined with time units which measure the time actually spent with the patient by the anesthesiologist in providing direct anesthesia care. Anesthesia time is defined by HCFA and by the ASA RVG as follows:

> Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

Note should be taken that this definition excludes time spent by the anesthesiologist with the patient both before and after the peri-operative period, for purpose of preoperative evaluation and usual required postoperative visits/notes. This care is considered to be included in the base units.

Even though all RVGs developed or used by Medicare carriers utilized the base unit and time unit system, substantial variations among those RVGs developed over the years -- creating anomalies from a national perspective.

For this reason, ASA strongly supported section 4048 of the **Omnibus Budget Reconciliation Act of 1987,** which mandated adoption of a Uniform RVG (URVG) for use by all Medicare carriers in reimbursement of anesthesia services. Pursuant to notice and comment in the Federal Register, HCFA adopted the 1988 edition of the ASA RVG as the URVG, for services provided on or after March 1, 1989. An important corollary to this was the adoption of the CPT-4 anesthesia codes, in lieu of surgical codes previously required on claims. The 4200 surgical codes are successfully complemented by only 248 broad anesthesia codes because the addition of anesthesia time measures the difference -- from the anesthetic standpoint -- between the many thousand surgical procedures. Adoption of the proper codes simplifies the system, accurately describes the anesthesiologists' service, and is in line with the general move toward code collapse.

Omnibus Budget Reconciliation Act of 1989

Prior to the Omnibus Budget Reconciliation Act of 1989, anesthesia time was counted and reimbursed in terms of units, one unit per each 15 minutes of anesthesia time when a procedure was personally performed and one unit per each 30 minutes of anesthesia time when the anesthesiologist was medically-directing nurse anesthetists. The actual time spent was always rounded up to the next whole unit, e.g., 2 hours and 3 minutes was reimbursed as if 2 hours and 15 minutes (or 30 minutes for medical direction services) of work were expended.

OBRA '89 contained a significant policy change regarding recognition of anesthesia time -- a change proposed by the Inspector General as a way to achieve accuracy of reimbursement and to eliminate even the potential for gaming; ASA supported this sound policy approach. Anesthesia time is now recognized in terms of actual minutes or fractional units. This not only achieved budget savings for the Program, but did bring tighter verification to anesthesia time and reduced possibilities of time manipulation.

Based on the Inspector General's study, which did not find fraud and abuse with regard to anesthesia time, the Congress legislated that actual anesthesia time, or fractional units, be incorporated into the Uniform RVG, effective January, 1990.

Most importantly, OBRA '89 also addressed anesthesia services with regard to their integration into the Medicare Fee Schedule. Section 1848(b)(2)(B) of the Social Security Act therefore states:

> In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustments in the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.
>
> The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish [radiology services and] anesthesia services in applying subparagraphs (A) and (B).

ASA believes the intent of Congress is crystal clear: The URVG, including base units plus actual time, should be retained under the Medicare Fee Schedule. There is no statutory language directing the Secretary to ignore or repeal the actual anesthesia time provision.

HCFA has contravened the intent of OBRA '87 and OBRA '89 by proposing the elimination of anesthesia time.

ASA believes HCFA's concern is not based on preserving the specialty of anesthesiology, or on dollars, or on fairness to physician and patient. We believe it is HCFA's administrative displeasure at the prospect of one specialty having a different conversion factor under the MFS. Indeed, as stated in the June 5 Federal Register, "First, program administration would be simplified." What could be simpler than continuing the existing claims processing procedure for anesthesia services?

Methodology and Rationale

It bears repeating that surgeons, not anesthesiologists, control time. Indeed, as noted by Dr. Hsiao:

> Anesthesia procedures are unique in that they are always rendered in combination with another service. Usually, the two services -- the anesthesia and an invasive procedure -- are performed by two physicians, one an anesthesiologist, the other a surgeon. Typically, therefore, the length of time the anesthesiologists' services are required for any given procedure depends upon the patient's condition and upon the time needed by the surgeon. Consequently, one of the key elements of anesthesiologists' work input is not under the direct control of the anesthesiologist. (A National Study of Resource-Based Relative Value Scales for Physician Services, Volume I, p. 586)

> Hsiao further recognized that the base unit values which his study found persuasive are incomplete without the addition of time: "Relative to the other components of the ASA relative value scale, time is intended to dominate." (p. 588) While Hsiao did not rule out average time, the report stated: "Given the evidence that surgeons, not anesthesiologists, determine the total time required for a particular surgical procedure, it can be argued that the relative value units for each anesthesia service performed should reflect the predetermined basic value plus the actual time involved." (p. 589)

HCFA continues to insist that fairness can be achieved through averaging. In practice, however, the variations in time, case mix, and caseload point to the impossibility of fairness through averaging of time units. The elimination of time will adversely affect those whose caseloads include disproportionate numbers of longer or medically complicated cases, and particularly those anesthesiologists practicing in tertiary care and teaching hospitals. Such a system would cause a financial incentive to work only in the outpatient setting with healthy patients.

In the proposed Medicare Fee Schedule, HCFA rejects ASA's arguments that average times are grossly inequitable and would lead to systematic over-and under-payments and that those anesthesiologists who work on more complex procedures or with slower surgeons would be adversely affected on all cases. Yet, HCFA states in the proposed rule that the elimination of time is budget neutral. We agree that it is budget neutral -- because averaging will redistribute dollars among anesthesiologists depending on their practice setting and surgical scheduling. HCFA cannot reject the inequity, which is supported by the budget neutrality.

We can only use the word "mysterious" to describe the calculations which were made between Phases I and II of the Hsiao Report and between the Hsiao numbers and the HCFA MFS. It has been a process disguised by double talk and marked with a lack of disclosure. We have not been able to determine how the calculations of pre- and post-anesthesia work were done. However, we do know that the mechanism used by Hsiao to estimate pre- and post-effort was based on individuals' responses for only three procedures -- three abdominal surgical procedures which would obviously not reflect the spectrum of anesthetic procedures.

For all other specialties, the mean responses of groups were run in a regression analysis. Three procedures, however, are not enough for a regression analysis, so Hsiao used the observations of a few individual physicians. The practice expense for anesthesiologists was treated in a manner different from all other specialties, and we believe that overhead was reduced twice between Hsiao II and the MFS. Finally, anesthesia work values were reduced 36 percent due to the highly questionable crosslinks. As an example, one such link equates anesthesia for repair of an abdominal aortic aneurysm with the obstetrician's time spent with a patient in protracted labor.

Over and above our objections to the elimination of time, HCFA's methodology for averaging is seriously flawed. In essence, HCFA collected anesthesia times from claim forms and then developed "average" times for procedures. These averages were added to the base units contained in the URVG. For the 19 procedures studied by Hsiao, the resulting total was divided into the total units from Hsiao II to yield a ratio. The resulting average ratio derived from the 19 procedures was then multiplied by the base and average time units for all 248 anesthesia codes. Fortunately, the problems with this approach are more easily explained than the process.

1. As discussed, Dr.Hsiao accepted the concept of anesthesia time, but did not include anesthesia time in the RBRVS because he had not resolved integration issues. Also, the estimates of pre- and post-work, based on three similar procedures are not reliable or representative.

2. HCFA is now adding specific time increments to the evaluation and management codes. Time is a valid measure and should be retained for anesthesia.

3. HCFA has applied average times to the anesthesia CPT-4 codes, which we have explained are highly collapsed and cover 4,200 surgical codes. The codes cover widely varying surgical procedures with widely varying times. Consider just a few examples:

Anesthesia Code	Number of Surgical Codes
00140 eye procedures	202
00160 sinus surgery	78
00540 chest surgery	49
00562 cardiac bypass	90
00840 abdominal surgery	116

HCFA did not even collect times for more than 50 percent of the anesthesia codes. Instead, average times were "imputed" by applying the times collected for codes with the same base unit values to all procedures with that base unit value.

* For example, HCFA has no time information for code 00216, intracranial vascular procedures, a difficult anesthetic procedure which has a base unit value of 15. According to the meager HCFA data, there is more than an hour difference in the minimum and maximum times reported for all procedures with 15 base units. So, code 00216 gets an arbitrary assignment of the average time of the reported times.

* Code 01832, anesthesia for total wrist replacement, has a base unit value of 6. The times collected by HCFA for procedures with 6 base units range from 48 minutes to nearly three hours. Because code 01832, anesthesia for total wrist replacement, did not have time data collected, HCFA imputed an average time for wrist replacement, arbitrarily setting it at one hour and 47 minutes.

GAO Report

HCFA relies on a report recently submitted by the General Accounting Office as part of its justification for the elimination of time. ASA rejects this simplistic and judgmental report (termed "not statistically significant" by the Inspector General) and we have attached our comments submitted to the GAO. In essence, the GAO concludes that if an anesthesiologist has some extra time between cases, he or she will go find the next patient and start the anesthetic in order to "gain" some time units. This unsubstantiated allegation conjures up visions of hospital corridors lined with anesthetized patients - maybe even days before the scheduled surgery.

In all seriousness, this is patently absurd and totally ignores the complexity of operating room scheduling. If there is a real incentive, it is not for the anesthesiologist to linger over any one case, but to start a new case with new base units.

Physician Payment Review Commission

The Physician Payment Review Commission (PPRC) has consistently supported the move to actual anesthesia time. In its 1990 Report to Congress, PPRC found that the URVG, including time, is resource based and is appropriate for use in the Medicare Fee Schedule. In its most recent 1991 Report to Congress, the PPRC recommends that "Medicare should continue to pay for anesthesia services on the basis of base units and actual time." (page 208) The PPRC goes on to state:

> The use of actual time has been justified because the anesthesia time for a surgical service varies widely due to differences in surgical time and is largely outside the control of the anesthesiologist or CRNA. Actual anesthesia time extends from when the anesthesiologist or CRNA prepares the patient for induction (administration) of anesthesia to when the patient is placed under postoperative supervision of others....The best option appears to be the continuation of the current policy of paying for anesthesia services on the basis of actual time. (page 210)

ASA agrees with the PPRC that the definition of anesthesia time can be tightened and we offered suggestions (e.g., wording clarifying that continuous presence is intended) to HCFA. These suggestions were either ignored or rejected. We also have supported PPRC's recommendation that time be independently verifiable and believe that such verification would be relatively simple to achieve.

The Conversion Factor

ASA was shocked at the unexpected level of reductions proposed by HCFA. Our specialty had been preparing for an 18 to 20 percent cut; HCFA now estimates an unbelievable 35 percent reduction. HCFA has transformed the RBRVS -- designed to realign payments

among specialties -- into a harsh, indeed unlawful, budget cutting tool. ASA objects in the strongest terms to this undermining of the RBRVS and HCFA's attempt to achieve $3 billion in savings from the MFS.

ASA also opposes the use of the behavioral offset, which in essence encourages the behavior it protests. Anesthesiologists do not control volume. Further, we do not accept HCFA's premise that our surgical colleagues will be seeking out and performing unnecessary surgeries in response to MFS changes. The Medicare Volume Performance Standard was created by the Congress as a monetary control on volume and it should be allowed to work.

Considering the significant reductions which have been absorbed by anesthesiologists over the last several budget cycles, including FY 91's 7 percent reduction, we know that the cumulative cut is far deeper than the 35 percent now forecast. Anesthesiologists are already reimbursed on a relative value system, so comparison of the previous and proposed conversion factors is achieved easily. In 1990, the national average Medicare allowed conversion factor for anesthesiologists was $20.20. If we were to express the proposed reductions in terms of anesthesiologists' existing reimbursement system, we see the Medicare conversion factor drop to the $11 range -- this is nearly a 50 percent cut. These losses are simply unjustified and unacceptable.

In fact, the conversion factor for anesthesiologists would be so reduced as a result of the proposed MFS that medically directed certified registered nurse anesthetists' (CRNA) pay rates -- set by OBRA '90 -- would be 95 to 100% of the physician rate. The rates set by OBRA '90 for non-medically directed CRNAs would exceed those for physicians by 40 percent. These CRNA rates were not set arbitrarily by the Congress, but were predicated on the expected reductions for anesthesiologists. As stated by HCFA in the June 5 Federal Register: "It is our understanding that the CRNA conversion factors were established by the Congress based on an estimate of anesthesiologist conversion factors under the fee schedule using data from Phase I of the Harvard study."

Reimbursement to Teaching Anesthesiologists

HCFA has chosen the proposed MFS as a vehicle to change reimbursement for teaching anesthesiologists. HCFA cites the current rules as an unfair incentive for anesthesiologists to use residents rather than CRNAs . We object to the proposal and further we do not believe the MFS is the appropriate regulation to address this non-fee schedule issue, and we object to the arbitrary singling out of this specialty for treatment different than other teaching physicians. When a comprehensive review of the rules for attending physicians is undertaken (and we have every reason to believe that this is pending), then we will be happy to work with HCFA on this issue. Medical education represents, obviously, the future availability of health care in this country. It is more than unfortunate that no one is willing to pay for it.

Conclusion

As a specialty which has embraced and defended the fairness of the relative value guide method in the Congress, the courts and innumerable state agencies, we are quite frankly awed by the way in which HCFA has converted this highly useful reimbursement tool into a budgetary bludgeon. We believe it is incumbent on the Congress to guarantee that implementation of the Medicare Fee Schedule is fair and not marked with inequities and gross inaccuracies that will build in perversities from the beginning. If reform is to work and have the support of both patients and physicians, it is imperative that Congress step in and get the train back on track.

Mr. McDermott. Thank you, very much.
Dr. Moorefield.

STATEMENT OF JAMES M. MOOREFIELD, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY

Dr. Moorefield. Thank you, very much, Mr. Chairman.

I am Dr. James Moorefield, and I am a radiologist from Sacramento, Calif., and chairman of the board of chancellors of the American College of Radiology. I appreciate the opportunity to share our feelings on the Bush administration's proposed Medicare fee schedule for 1992.

The ACR believes that the fee schedule, as proposed 3 weeks ago by the Health Care Financing Administration, is virtually a complete violation of the intent and spirit of physician payment reform. There are many issues in the fee schedule to which we object. I will concentrate on four and ask that we have the opportunity to submit further comments to the subcommittee in the coming days.

The proposed fee schedule ignores the fact that physician payment reform began 4 years ago. Radiology procedures, among others, have been subjected to reductions over the last 4 years. These reductions have been made under legislation aimed at reform of Medicare payments to physicians. None of these prior reductions have been taken into account in the proposed fee schedule. For radiologists this amounts to an additional 18 percent.

OBRA of 1990 determined remaining reductions in radiology payments through 1996 to be of the order of 13 percent, and 9 percent of this has already occurred in 1991. It is unconscionable that the administration has chosen to ignore the significant reductions that we have already contributed to physician payment reform. If this fee schedule were to be implemented, radiology procedures in 1996 would be reduced by 50 percent from the 1988 base year used in physician payment reform studies. No study, public or private has ever categorized radiology procedures as overvalued by 50 percent.

The second issue of concern to us is the transition offset. A reduction of greater than 6 percent has been made to the conversion factor because of HCFA's interpretation of the transition rules contained in the law, and the legal requirement for budget neutrality. Again, HCFA has ignored the fact that some specialties and some procedures began the transition in physician payment 4 years ago.

We, too, believe it was the intent of Congress that the whole of physician payment reform be budget-neutral and that it be phased in, in a reasonable way, not that some specialties should experience additional cuts in implementing the reform.

The next issue we must address is the behavioral offset. To our knowledge, HCFA has never published data or analysis subject to public review and scrutiny which justifies their contention of a 50-percent volume response to payment reductions. In fact, Medicare's data, BMAD data for radiology, if we might give that as an example, since the radiology fee schedule was implemented has shown an abatement of growth of volume of radiology procedures since that time.

I also would like to note that the PPRC has recommended a 1-percent behavioral offset instead of HCFA's 3 percent. Therefore, it is clear that before such an adjustment is made to conversion factors there should be a thorough study of behavioral response that offers data and analysis that can support it. This study should be subjected to public scrutiny before a behavioral offset is used.

The final issue we must address is that of geographic practice cost adjustments. While we are aware that HCFA has utilized indices to adjust for differences in practice costs across the country, these adjustments become meaningless in light of the reductions described above. For those physicians practicing in areas where payments have been historically suppressed, there is no relief from the historical bias. Rural physicians have little to cheer about when told by HCFA that their payments will be adjusted to more equitably reflect the differences in practice costs, when their conversion factor has been slashed more than 16 percent. And if they are radiologists the value of their procedures has been subjected to a double reduction for overvaluedness.

Mr. Chairman, in 1987, my colleague and former president of the American College, Dr. Joseph Marasco, appeared before this subcommittee and discussed with you the possibility of the American College of Radiology working with the Congress and HCFA to devise a fee schedule for radiology services.

The Congress agreed and we have spent the last 3 years working with HCFA and American radiologists to make a fee schedule for Medicare work. It has required a great deal of effort and sacrifice. We agreed to work with you because we sincerely believed we could develop a payment scheme that was fair and equitable. Until June 5, 1991, we believed we were doing just that. The Bush administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and your assistance in putting physician payment reform back on the right track.

Thank you.

[The prepared statement follows:]

Statement of the
American College of Radiology
to the
U.S. House Ways and Means
Subcommittee on Health

Presented by James M. Moorefield, M.D.
Chairman, ACR Board of Chancellors

June 25, 1991

The following comments are submitted on behalf of the over 20,000 physician members of the American College of Radiology. The comments are submitted concerning the Bush Administration's proposed rule in implementing a Medicare fee schedule for physician services as published in the *Federal Register*, June 5, 1991.

Thank you Mr. Chairman. I am James Moorefield. I am a radiologist from Sacramento and chairman of the Board of Chancellors of the American College of Radiology. I appreciate the opportunity to share our feelings on the Bush Administration's proposed Medicare fee schedule for 1992.

The ACR believes that the fee schedule, as proposed three weeks ago by HCFA, is a total violation of the intent and spirit of physician payment reform. The Bush Administration's action on the physician fee schedule is nothing short of draconian.

There are many issues in the fee schedule to which we object. I will concentrate on four and ask that we have the opportunity to submit further comments to the subcommittee in the coming days.

The proposed fee schedule completely ignores the fact that physician payment reform began four years ago. Radiology procedures, among others, have been subjected to reductions over the last four years. These reductions have been made under legislation aimed at reform of Medicare payments to physicians. None of these prior reductions have been taken into account in the proposed fee schedule. For radiologists, this amounts to an additional 20 percent cut.

It is unconscionable that the administration has chosen to ignore the significant reductions that we have already contributed to physician payment reform. If this fee schedule were to be implemented, radiology procedures in 1996 would be reduced by 50 percent from the 1988 base year used in physician payment reform studies. No study, public or private, has ever categorized radiology procedures as overvalued by 50 percent.

The second issue of concern to us is the transition offset. A reduction of greater than ten percent has been made to the conversion factor because of HCFA's interpretation of the transition rules contained in the law and the legal requirement for budget neutrality. Again, HCFA has ignored the fact that some specialties and some procedures began the transition in physician payment four years ago. We believe it was the intent of Congress

that the whole of physician payment reform be budget neutral and that it be phased-in in a reasonable way, not that some specialties should experience additional cuts in implementing the reform.

The next issue we must address is the behavioral offset. To our knowledge, HCFA has never published data or analysis for public review and comment which justifies their contention of a 50 percent volume response to payment reductions. In fact, Medicare actuary's data show that volume growth has been slightly slower from 1984 to the present, than for the period before 1984. Obviously, from 1984 to 1991, Medicare fees have been significantly constrained. This data contradicts the volume response contention.

I also note that the Physician Payment Review Commission recommended a one percent behavioral offset instead of HCFA's 3 percent. It is clear that before such an adjustment is made to conversion factors, there should be a thorough study of behavioral response that offers data and analysis to support it. This study should be subjected to public scrutiny before a behavioral offset is used.

The final issue we must address is that of geographic practice cost adjustments. While we are aware that HCFA has utilized indices to adjust for differences in practice costs across the country, these adjustments become meaningless in light of the reductions described above. For those physicians practicing in areas where payments have been historically suppressed, there is no relief from the historical bias. Rural physicians have little to cheer about when told by HCFA that their payments will be adjusted to more equitably reflect the differences in practice costs, when their conversion factor has been slashed more than 16 percent. And if they are radiologists, the value of their procedures has been subjected to a double reduction for overvaluedness.

Mr. Chairman, in 1987, the American College of Radiology (ACR) appeared before this subcommittee and discussed with you the possibility of the ACR working with the Congress and HCFA to devise a fee schedule for radiology services. You agreed. The Congress agreed and we have spent the last three years working with HCFA and American radiologists to make a fee schedule for Medicare work. It has required a great deal of effort and sacrifice.

We agreed to work with you because we sincerely believed we could develop a payment scheme that was fair and equitable. Until June 5, 1991, we believed we were doing that. The Bush Administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and assistance in putting physician payment reform back on the right track.

Thank you Mr. Chairman.

Mr. McDermott. Thank you, Dr. Moorefield.
Dr. Winters.

STATEMENT OF WILLIAM L. WINTERS, JR., M.D., F.A.C.C., IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY

Dr. Winters. Thank you, very much, Mr. Chairman.

Good afternoon, my name is William L. Winters, Jr., and I am the immediate past president of the American College of Cardiology. I am a practicing cardiologist also from Houston, for the past 30 years. The college is an 18,500-member nonprofit professional medical society and teaching institutions whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion and research, and leadership in the development of standards and formulation of health care policy.

I am pleased to appear before you again to comment specifically on HCFA's proposal for implementing the Medicare fee schedule. I would like to focus my verbal remarks, which are intended solely to positively affect this process, on the following four topics: the value of the professional interpretation of electrocardiograms; the assignment of relative value units to visit codes; payment for the technical component of diagnostic services; and the absence of payment or ranking information to evaluate entire groups of important classes of cardiovascular specialty services including echocardiography, and coronary artery bypass surgery.

As the committee knows, the college strongly objects to the implementation of the Omnibus Budget Reconciliation Act of 1990 provision that eliminates payment for the professional interpretation of electrocardiograms. It seems to us there is no factual or rational basis for this provision. The medical community was given no opportunity to provide input prior to the passage of this law. As we have testified in the past, and as has the PPRC and 15 other health organizations declared, we feel the law should be repealed.

HCFA's proposal for implementation of the law includes an attempt to recognize some value for ECG interpretation through the incorporation of a markup for the ECG into payment for office visits. Unfortunately, this results in underpayment of physicians who perform ECG's and overpayment for those who do not. The result signals the undermining of an important goal of physician payment reform—to pay for physician services based on true resource costs regardless of specialty.

We urge Congress to modify the ECG provision and to urge you to consider the adoption of PhysPRC's recommendation to reinstate appropriate payment for ECG interpretation. For our part, the ACC and the American Heart Association will complete medical practice guidelines for electrocardiography this October. This seems to us a more appropriate mechanism with which to protect Medicare beneficiaries of this medical service.

I would also like to bring to your attention our concern that the payment of the technical component of ECGs may be inappropriately included in the proposed regulation. The technical payment would be denied if the diagnostic services is considered to be covered by the visit. Under current law, this could be interpreted to include ECGs. We believe Congress intended, in the OBRA 1990

report, that payment would continue to be made for the technical component of the ECGs performed as an outpatient.

So far as visit codes are concerned, an explicit goal of the Congress in physician payment reform has been redistribution of Medicare and physician payments from procedural to evaluation and management services. Reductions in the procedural services were expected to be offset by an increase in payment for visits. Instead we estimate that cardiovascular specialists will experience a 4-percent reduction in 1992 from 1991 for evaluation and management service payments, on top of substantial reductions for procedures which have already occurred and will continue in the first year of the Medicare fee schedule.

While we recognize that the proposed reimbursement for visits is, in part, related to the conversion factor, the calculation of the conversion factor is based, in large part, on the assumptions made by HCFA as to how physicians will use the new coding system for visits. And although HCFA supported an AMA pilot test to determine how physicians would use the new visit coding system, recent deliberations at a PPRC hearing revealed that HCFA did not utilize the results of this study to project the total number of visit RVUs expected in 1992.

We urge that some attempt be made to utilize the pilot test results to support this important element of the new payment method.

As noted earlier in relation to ECG services, the college is troubled by several aspects of HCFA's proposal for calculating the technical component of diagnostic tests. For example, for some services it is difficult to determine the true costs of the technical component when that service is routinely billed as a complete procedure in the office or as a professional component only in the hospital.

Using the difference between the global and the professional fees may be an adequate interim measure; however, ACC strongly urges HCFA to collect data to more accurately assess the costs of the technical components.

Neither Congress nor the administration plan to subject physicians to major payment changes without an opportunity to comment. And the college is now alarmed, however, that this may, indeed, happen. Several key services provided by cardiovascular specialists are not listed in the regulations and have not been assigned RVUs. The total absence of certain classes of codes such as echocardiography, and electrophysiology, and only a single code for coronary bypass surgery is unacceptable. We think this deserves further attention.

The ACC joins the rest of medicine in opposing the implementation of HCFA's proposed conversion factor. It is our understanding that physician payment reform was intended to be budget-neutral and in reality Medicare payments to physicians will decrease by 16 percent in the aggregate over the next 4 years, without accounting for previous reductions taken from 1988 to 1990.

Two factors which have already been well discussed include unanticipated effect of the transition from historical fees to the Medicare fee schedule, and the assumption by HCFA that physicians will increase their volume of services by 50 percent. The Medicare volume performance standard is a device intended to control the

volume of physician services that already exists. And we do not believe it was the intent of Congress to cut physician fees an additional 16 percent.

HCFA plans to publish a national list of procedures subject to the site of service limitations and it is also considering including services which are performed less than 50 percent of the time in the office, but which exceed volume threshold. According to the testimony of the Inspector General's Office this would apply to many consultations, of which cardiologists provide many.

Although the limit would apply only to the practice expense component of the fee schedule amount, the practice expense for consultations consist primarily of billing and overhead costs, which are legitimate expenses in both office and hospital settings.

The college is concerned about the application of a greater than 90-day postoperative period for certain services, such as coronary artery bypass. While the patient may require longer than 90 days to fully recover, typically the care of the patient is transferred back to the primary physician well in advance of the 90-day limit.

Under a global fee system for payment for surgical services, HCFA proposes that each physician be directly paid for services furnished to the beneficiary based on the relative value units of the component furnished. More information is needed to determine how this approach would work and what impact it would have on the relations among patients and physicians.

And also to determine the relative value units for the separate components of care when more than one physician provides the care, HCFA has suggested working with a preoperative, intraoperative, and postoperative segment breakdown. It plans to apply one standard percentage of breakdown to an entire surgical family. For example, virtually all cardiovascular surgical services are included in the same family, using the pacemaker breakdown as the standard.

The mix of pre-, intra-, and post-operative input varies significantly among cardiovascular services, and we cannot support the use of this simplistic generic formula based on a single service to be applied all across cardiovascular services.

If HCFA maintains this approach the college believes the family should at least be made smaller so that the payment will more accurately reflect the service provided.

In summary, Mr. Chairman, the college believes the support of the physician community is essential to the successful implementation of the Medicare fee schedule. To meet the goals of physician payment reform there are simply too many unresolved issues in the proposed Medicare fee schedule regulation for us to feel confident that this reform effort will result in more good than harm. We stand ready to work with you and the administration to try to resolve these very major and diverse problems.

Thank you, again, for permitting us to testify.

[The prepared statement follows:]

Statement of the
AMERICAN COLLEGE OF CARDIOLOGY

My name is William L. Winters, Jr., M.D., F.A.C.C., Immediate Past President of the American College of Cardiology and a practicing cardiologist for over three decades. The College is an 18,500 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Thank you, Mr. Chairman, for the opportunity to provide this distinguished Subcommittee with the College's initial assessment of the Health Care Financing Administration's (HCFA) notice for proposed rulemaking implementing the Medicare fee schedule (MFS) beginning in 1992. The College takes issue with several aspects of the proposed rule, but is most concerned with: 1) recognition of the value of the professional interpretation of electrocardiograms (ECG); 2) the assignment of relative values units (RVUs) to visit codes; 3) the development of RVUs for the technical component of diagnostic services, and 4) the absence of RVUs for several important classes of cardiovascular specialty services including echocardiography and coronary artery bypass graft surgery (CABG).

Electrocardiograms (ECGs)

As this Committee knows, the College strongly objects to the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA90) provision that eliminates payment for the interpretation of electrocardiograms. **There is no factual basis for this provision.** The medical community was given no opportunity to provide input prior to the passage of this law. As we have testified in the past and as the PPRC and 15 other health organizations have declared, the law should be repealed.

To make matters worse, HCFA's proposal for implementation of the law includes an attempt to recognize some value for ECG interpretation through the incorporation of a "mark-up" (additional RVUs) for the ECG into payment for visits. Unfortunately, this results in underpayment of physicians who perform ECGs and overpayment of those who do not, undermining an important goal of physician payment reform: to pay for physician services based on true resource costs, regardless of specialty.

As PPRC stated in its March 1991 Report to Congress (page 255):

> Although bundling EKG interpretations with visits could encourage more appropriate utilization and result in budget savings, it would create inequities among specialties and physicians because of differences in the average number of EKGs performed per visit. For example, Medicare claims files show that cardiovascular physicians bill Medicare for more than four times as many EKGs per office visit as the average physician. Variations among individual physicians are even greater.

If HCFA's plan is implemented, the incremental increase for office visits would be .024 RVUs or 65 cents on the MFS common scale. It is evident that this approach is both inappropriate and inequitable, particularly in light of the fact that HCFA has already assigned a stand-alone value of .18 work RVUs to ECG interpretation.

The College stands ready to support congressional attempts to modify the ECG provision, and to adopt PPRC's recommendation to reinstate payment for ECG interpretation. A more appropriate mechanism with which to protect Medicare beneficiaries from the overuse, underuse or misuse of any medical service is the adoption of well developed and tested practice guidelines. Toward this end, the ACC and the American Heart Association will complete guidelines for electrocardiography this October.

We are also concerned that the payment of the technical component for ECGs may be inappropriately included in the proposed regulation. The technical payment would be denied "if the 'diagnostic' service is considered to be covered by the visit." Under current law, this could be interpreted to include ECGs. Congress intended, in the OBRA90 report, that "payment would continue to be made for the technical component of ECGs performed on an outpatient basis."

Visit Codes

An explicit goal of physician payment reform is to redistribute Medicare physician payments from procedural to evaluation and management services. Reductions in procedural services were expected to be offset by an increase in payments for visits. Instead, our preliminary estimates show that cardiovascular specialists will experience a 4 percent reduction in 1992 from 1991 for evaluation and management service payments on top of substantial reductions for procedures in the first year of the MFS implementation (based on 1989 national average allowed charges to 1991, BMAD-1 data and OBRA 89 and 90 updates for visit codes).

While we recognize that the proposed reimbursement for visits is in part related to the conversion factor, the calculation of the conversion factor is based in large part on the assumptions made by HCFA as to how physicians will use the new coding system for visits. Although HCFA supported an AMA pilot test to determine how physicians would use the new visit coding system, recent deliberations at a PPRC hearing revealed that HCFA did not utilize the results of this study to project the total number of visit RVUs expected in 1992. We lack confidence that the proposed visit RVUs and aggregate RVUs represent reality and urge that some attempt be made to utilize the pilot test results to support this important element of the new payment method.

Technical Component of Diagnostic Tests

As noted above in relation to ECG services, the College is troubled by several aspects of HCFA's proposal for calculating the technical component of diagnostic tests. For example, for some services it is difficult to determine the true costs of the technical component when that service is routinely billed as a complete procedure in the office or as professional component only in the hospital. Using the difference between the global and professional fees may be an adequate interim measure; however, the ACC strongly urges HCFA to collect data to more accurately assess the costs of technical components of diagnostic services.

Missing Services

Subjecting physicians to payment based on relative values for services for which no opportunity to comment was provided is inappropriate. The College is alarmed by the missing RVUs for several key services provided by cardiovascular specialists from the proposed rule. The total absence of certain classes of codes such as coronary artery bypass graft surgery, echocardiography, and electrophysiology is unacceptable. Even if values established before 1992 are considered temporary, it is likely that changes would not take place for at least a year, resulting in considerable disruption in the delivery of necessary cardiovascular services to Medicare beneficiaries. Only one echocardiography code, a technical component of doppler echo, was included on HCFA's list and this service has not even been surveyed.

Conversion Factor

The ACC joins the rest of medicine in opposing the implementation of HCFA's proposed conversion factor. Physician payment reform was intended to be budget neutral, and in reality, Medicare payments to physicians will decrease by 16 percent over the next four years, without accounting for previous reductions taken from 1988 - 1990. Two factors inappropriately reduce the conversion factor: 1) the unanticipated effect of the transition from historical fees to the

Medicare fee schedule and; 2) the assumption by HCFA that physicians will increase the volume of services by 50 percent.

The College urges Congress to pass legislation to correct the transition problem. We do not believe it was the intent of Congress to cut physician fees by an additional 16 percent. Also, the Medicare Volume Performance Standard (MVPS), a device intended to control the volume of physician services, already exists.

Other Issues

Site of service differential--HCFA plans to publish a national list of procedures subject to the site of service limitation (those performed more than 50 percent of the time in the physician's office). HCFA is also considering including services which are performed less than 50 percent of the time in the office, but which exceed a volume threshold. According to testimony of the HHS Inspector General's office, this would apply to many consultations. Although the limit would apply only to the practice expense component of the fee schedule amount, the practice expense for consultations consists primarily of billing and overhead costs, which are legitimate expenses in both office and hospital settings. This results in another major and unwarranted reduction in an essential cognitive service for the diagnosis and treatment of Medicare patients with heart disease.

Global Surgery Definition--The College is concerned about the application of a greater than 90-day post-operative period for certain services, such as coronary artery bypass graft (CABG) surgery. While a patient may require longer than 90 days to fully recover, typically the care of the patient is transferred back to the primary physician well in advance of the 90 day limit.

Concurrent care--Under a global fee system for payment for surgical services, HCFA proposes that physicians each get directly paid for the services furnished to the beneficiary based on the RVUs of the component furnished. More information is needed to determine how this approach would work and what impact it could have on relations among patients and physicians.

Also, to determine the RVUs for the separate components of care when more than one physician provides the care, HCFA has suggested working with a preoperative, intraoperative and postoperative segment breakdown, and plans to apply one standard percentage breakdown to an entire surgical family. For example, virtually all cardiovascular surgical services are included in the same family, using the pacemaker breakdown as the standard. The mix of pre-, intra-, and post-operative inputs varies significantly among cardiovascular services and we can not support the use of a simplistic generic formula based on a single service to be applied across all cardiovascular surgical services. If HCFA maintains this approach, the College strongly believes the families should be made smaller so that the payment will more accurately reflect the service provided.

Summary

In summary, Mr. Chairman, the College believes the support of the physician community is essential to the successful implementation of the Medicare fee schedule. To meet the goals of physician payment reform, there are simply too many holes in the MFS regulation and the proposed fee schedule for us to feel confident that this reform effort will result in more good than harm. We stand ready to work with you and the Administration to try to resolve these very major problems but we are starting to believe that January 1, 1992 may be an overly ambitious goal for ever beginning to implement this fee schedule.

Thank you again Mr. Chairman and members of the Subcommittee for the opportunity to testify.

Chairman STARK [presiding]. Thank you, Dr. Winters.

I want to thank the panel. I'm not sure I have ever dealt directly with the cardiologists, much to my dismay, but certainly the radiologists and the anesthesiologists and this subcommittee have become well acquainted over the last several years. You all are content, those of you who have had to deal with us for one reason or another, that you are getting a fair hearing in this committee and that we're keeping our agreement as between your particular specialties, radiology and anesthesiology, to get done what we thought we were going to get done?

Dr. MOOREFIELD. As I said, Mr. Chairman, up until June 5, we thought we were well on the road. Frankly, in my position as chairman, I thought the biggest job was behind me and that we would be picking up little bits and pieces from here and there.

Chairman STARK. You and me both.

Dr. MOOREFIELD. But as of the notice of proposed rulemaking, it seems like we're back to square one in many ways. But the answer to your question, as far as this committee and Congress, in general, yes, very fair.

Chairman STARK. Dr. Stephenson.

Dr. STEPHENSON. Since you gave about half of my testimony, yes, sir, I believe I have.

Chairman STARK. Well, I'm not sure whether it was Mr. Archer or Mr. Pickle that wrote it for me, or Mr. Andrews, but one of those gentlemen must have had something to do with it.

I must say I am in a dilemma, I have held off having a physical exam for several years because my internist in California is basically a cardiologist and until I get this EKG thing resolved I don't dare show up because he now tells me he is training to become a proctologist and that may be the longest physical exam I will ever have had, unless I can come to an agreement with him, Dr. Winters.

I think that you all realize in spite of the fact that we may have some problems on physician ownership—I'm not sure with your association but with some of your members—that we are trying to get this reimbursement thing to work. To try to get it into a position where we can argue about things that this committee knows about; what we're going to pay, and what we're going to deliver out of the trust fund for services under part B.

As to what those services ought to be and how many, and how much per service, as was illustrated today, we don't know. But if you're content—and that's part of the purpose of these hearings—we should be able to get this resolved to the point where we can have a system that is somewhat more simple to deal with and to bargain from. Then I think we can go ahead and you can go about the practice of medicine; we can go about, the AMA notwithstanding, the business of getting reelected and we will live to come back and bargain again another year.

I appreciate your repeated trips to the Hill or the well, however you want to refer to us, and we will try and get this resolved. I would urge you, because I rather suspect that some of the members of your respective associations may have voted for the present administration, one or two. Now, if you can find a member or two who has supported the present administration, particularly from Texas, there is a key player from Texas, I would urge you to men-

tion this, at the other end of Pennsylvania Avenue, where all of this trouble started and that would help us kind of get it done.

We would like to work with you, with HCFA, with PhysPRC to get payment reform resolved and then the real argument is going to come of whether we're going to get to a national health insurance. I mean this is easy, once we get this behind us then the real argument can start, and we can have some fun with that one. This is just tacky little details that we ought to be able to get behind us.

So, thank you. I hope that at least certainly your professional associations are held in the highest regard by this subcommittee and all this subcommittee has, basically is its word, and I hope that we come out of these negotiations with that intact and we can go on.

Thank you.

The subcommittee is adjourned.

[Whereupon, at 1:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN ACADEMY of DERMATOLOGY, Inc.

PRESIDENT
Stephen B. Webster, MD
PRESIDENT-ELECT
Wilma F. Bergfeld, MD
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EXECUTIVE DIRECTOR
Bradford W. Claxton, CAE

July 2, 1991

The Honorable Fortney (Pete) Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The American Academy of Dermatology was not invited to present oral testimony at your recent hearing regarding physician payment reform and the Medicare resource-based relative value scale (RBRVS). Nevertheless, we would like to offer a brief comment for inclusion in the printed record of the June 25 hearing.

The American Academy of Dermatology, which represents over 95% of all the dermatologists practicing in the United States, supports physician payment reform. Over the past several years, the Academy has worked closely with the Hsiao research team and the Physician Payment Review Commission. We agree with you that physicians should be treated fairly, and that the reform measures should be faithfully implemented.

We are still analyzing the impact on our specialty of the recent proposed rules promulgated by the Health Care Financing Administration (HCFA) to implement reforms in physician payments under the Medicare program. However, we must add our voice of strong opposition to those of others who oppose the conversion factor that HCFA has proposed in its new physician payment schedule. We believe that this new conversion factor represents a 16% reduction that violates the express intent of the Congress.

Congress intended to increase payments for primary care services and services provided in rural areas while moderating the reduction in payments for certain procedures. Congress stipulated that the new payment system would be implemented on a budget-neutral basis. These reforms were to be implemented fairly. They were not to be used as a budget-cutting device.

The Academy supported physician payment reform based on Congressional assurances of fairness and budget neutrality. However, if the new system proceeds unchecked, the projected reductions will result in some physicians being paid at less than they receive for the same services under Medicaid. This will undermine physician payment reform before it is even implemented.

We strongly urge you to prohibit HCFA from implementing this physician payment schedule with the current conversion factor, which includes a "behavioral offset" factor, transition asymmetry, and a tripling effect of transition adjustments. We also encourage you to support amendments that are being developed to address this problem. In doing so, you will be helping us deal with the access to care problem and maintain continued physician support of Medicare.

Sincerely,

Stephen B. Webster

Stephen B. Webster, MD
President

STATEMENT OF THE AMERICAN ACADEMY OF NEUROLOGY

The American Academy of Neurology (AAN/the Academy) is pleased to provide a statement to the Subcommittee Health, Committee on Ways and Means on Medicare payments to physicians under the resource-based relative value scale (RBRVS) especially in light of the Administration's recently proposed rule which translates the RBRVS into a Medicare Fee Schedule for physician's services.

AAN appreciates Chairman Stark's and the Subcommittee's commitment to ameliorate the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a Medicare Fee Schedule which is both fair and equitable. While AAN will provide comments to HCFA on several areas of concern, we will focus our comments here on the most problematic to all of organized medicine – the reductions to the conversion factor.

Reductions in the Dollar Conversion Factor:

If the proposed rule were implemented as written, drastic, unnecessary and unanticipated reductions in physician fees of over $12 billion would be realized by 1996, due to conversion factor reductions of 16 to 22 percent, despite Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting devise. It is because of these reductions to the dollar conversion factor, more than any other reason, that physician payments will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained to the letter of OBRA '89, and therefore call upon the Congress to correct for them through legislative action. But, Congress need also mandate HCFA in other areas to reverse all of the unnecessary reductions to the dollar conversion factor proposed by HCFA which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

Behavioral offset adjustment: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4.5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

The Academy maintains that no behavioral offset assumption be employed by HCFA because the Volume Performance Standards will take care of any unanticipated increase in volume as they provided a mechanism for HCFA to recommend lesser updates if expenditures exceed the target. Regarding HCFA's arguments against having the VPS take care of all unanticipated volume increases, Congress could simply recommend greater reductions in updates if merited, or change the default formula. Furthermore, scientific data supporting the concept of a behavioral offset are not well developed nor uniformly accepted by HCFA, the Congressional Budget Office (CBO), and the Physician Payment Review Commission (PPRC). Given this, Congress should legislate that HCFA be prohibited from using a behavioral offset assumption in its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

Transition rules adjustment: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made; but HCFA staff now say that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6.2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

Crosswalk to the new visit codes: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions

made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

Summary of HCFA's conversion factor reductions:

-10.5%	behavioral offset – no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment – $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone – $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk – no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF – would translate into over $12 billion (plus savings due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS, despite Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. The Academy urges Congress to enact legislation which would return physician payment reform to the budget neutral basis on which is was intended. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further unnecessarily reduce the conversion factor.

The Academy is sensitive to the pay-as-you-go budget rules passed last year, and would prefer alternatives that would not trigger it. However, we cannot stand by and watch physician payment reform be brutalized by HCFA and by technical drafting errors. The Academy would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA), appreciates the opportunity to comment on the proposed rule for a Medicare fee schedule for payment for physicians' services (hereinafter fee schedule) contained in the June 5, 1991 Federal Register notice. As the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), AANA has great concerns about several of the provisions contained in the fee schedule.

As indicated in the notice, CRNAs are one of the seven nonphysician practitioner groups whose services are included in the fee schedule. We believe that the fee schedule, as proposed, would have a major impact on access to CRNA services, as well as payment for those services.

We would like to begin with a general comment on the proposed rule. We are strongly opposed to the use of a behavioral offset. We believe that Congress adopted the Medicare Volume Performance Standards as the way to deal with any potential increase in volume in physician services that may result from decreases in payments to some physician groups under the new fee schedule. If Congress had intended that HCFA use a behavioral offset, they would have legislated such a mechanism. The fact that the Omnibus Budget Reconciliation Act of 1989 (OBRA89) was silent on the issue meant that Congress did not advocate the use of a behavioral offset. The use of a behavioral offset for anesthesiologists is especially inappropriate in that neither anesthesiologists nor CRNAs control volume, with the exception of pain management. CRNAs and anesthesiologists do not determine the need for surgery, nor the length of the surgical procedure.

Our specific comments on the proposed rule will reference pages as they appear in the Federal Register notice.

Page 25797, column 1, through page 25798, column 1: "CRNAs"

The AANA will address four issues referenced in this section: budget neutrality of the CRNA fee schedule, the elimination of time as a separate payment element, the use of the same relative value scale for CRNAs and anesthesiologists, and the need for a CRNA's payment not to exceed an anesthesiologist's payment.

Budget Neutrality of CRNA Fee Schedule

We do not agree that HCFA developed an appropriate methodology for paying CRNA services when it implemented the Medicare CRNA fee schedule in the January, 1989 proposed CRNA fee schedule rule. We believe that the complexity of the HCFA budget neutrality computation at that time resulted in an unfair and inequitable CRNA fee schedule. We are still hopeful that this inequity will be remedied when the final CRNA fee schedule rule is issued.

Elimination of Time as a Separate Payment Element

The association has consistently opposed the outright elimination of the use of time units in the calculation of anesthesia payments for the following reasons:

- Anesthesia providers do not determine the length of the surgical procedure, therefore the anesthesia provider is not in direct control of how long it takes to do a case. Consequently, anesthesia providers could find themselves rewarded or penalized financially, not based on their productivity, but rather on arbitrary case assignments.

- If time units are eliminated, like modifier units before them, there will be no way to adjust for patient acuity and/or procedural complexity.

- We do not agree that payment fairness will be achieved through averaging. The elimination of time units will result in a redistribution of payment that will disproportionately affect CRNAs. The institutions that have the longest surgical procedures, and consequently the longest anesthesia times, are teaching hospitals, rural hospitals, and hospitals that treat a large number of Medicare patients. These institutions use CRNAs most often.

- Determining an average time for a procedure is difficult when the amount of time for a specific surgery can vary, for example, between 40 minutes and five hours.

The AANA believes that clear congressional intent to use time units was indicated in the Omnibus Budget Reconciliation Act of 1987 (OBRA87), which mandated the adoption of a Uniform Relative Value Guide (URVG) for use by all carriers when reimbursing for anesthesia services. HCFA subsequently adopted the 1988 edition of the American Society of Anesthesiology RVG and the CPT-4 anesthesia codes. The 248 anesthesia codes were able to replace the 4,200 surgical codes previously used, because the addition of anesthesia time units allows a differentiation between the several thousand surgical procedures. In OBRA89, Congress modified the use of time units to require that actual minutes be counted in fractional time units. The key point is that Congress did not statutorily eliminate time units in either OBRA87 or OBRA89, when they were directly addressing the time issue.

The proposed rule notes that the April, 1991, General Accounting Office (GAO) report "Medicare: Variations in Payments to Anesthesiologists Linked to Anesthesia Time" recommends the elimination of the direct link between anesthesia time and payment. The AANA shared the GAO's concern about the variation in the mean preoperative anesthesia time billed for by anesthesiologists in the hospitals studied. However, we do not believe that the limited sample size and variables studied provided reliable and valid data to support the inference that the variation in preoperative anesthesia time is based primarily on inefficiency or financial incentives to perform work slower. In fact, most institutions have full surgical schedules and, as a result, there is no incentive to start providing the anesthesia services for a procedure earlier than necessary because that would decrease the number of cases that could be done in a day. In addition, because surgeons are paid by the case and not by the length of time necessary to perform the surgery, most surgeons want to get their cases done in a timely manner so they can move on to the next case or get to their offices to see patients.

We also question the reliability and validity of any study that didn't address factors that contribute to the length of anesthesia time that are outside the control of the anesthesia provider, such as:

- Based on patient acuity, there may be a need for invasive monitoring. The insertion of invasive monitoring devices adds to preoperative time. (It is noteworthy to recall that when modifier units were eliminated, time units were then to reflect these concerns).

- Hospital case-mixes related to patient physical status, e.g. rural hospitals that have a greater percentage of Medicare patients who have higher rates of chronic diseases. As a result, they may be in a higher risk group overall for anesthesia, and thus cause an increase in preoperative anesthesia time.

- Hospital resources available to assist the anesthesia provider with the preoperative anesthesia preparation.

Institutional policy favoring the presence or absence of a preoperative holding area for some work prior to moving to the operating room may have a difference.

- The surgical preparation of the patient depends on the surgical equipment. The intraoperative preparation time, for example, in putting a hip fracture patient on the fracture table, may take longer than the actual surgical procedure itself.

- Delays when the surgeon or procedural physician must leave to deliver a baby, is called to provide emergency room care, or chooses to consult with another physician.

- Patient complications during induction.

- The type of anesthesia is sometimes chosen by the surgeon or procedural physician and one type of anesthesia may take longer to implement than another, i.e. regional versus general. Also, when epidural or spinal anesthesia is given, additional time may be required for preloading the patient with fluid, a variation which may have accounted for some of the differences in the group of patients having prostrate surgery. In some cases, both regional and general anesthesia is provided for patient safety, pain management, or other reasons.

- Assistance available during induction (if other health care providers start the IV or insert a Swan Ganz, arterial line, or a central venous catheter).

- Teaching hospitals may have longer preoperative time related to the training of anesthesia providers and surgical residents. The level of students, and the instructor to student ratio, would also be a factor in the length of preoperative time.

- In some surgical procedures, anesthesia may represent the greatest risk to the patient and thus warrant a greater amount of time than the surgery.

In our comments on the GAO draft report on anesthesia time, we stated that we believe that the crux of the problem with billing for preoperative time is that the current definition of anesthesia time is ambiguous. We believe that what is needed is a clear statement that actual physical presence is required for purposes of billing for preoperative anesthesia time. Therefore, we propose the following definition of anesthesia time:

> **Anesthesia time begins with the actual physical presence of the anesthesia provider with the patient for the purpose of immediately preparing the patient for anesthesia care in the operating room or an equivalent area. The anesthesia time ends when the patient has been transferred to the continuous care of a licensed individual and the physical presence of the anesthesia provider is no longer required.**
>
> **The anesthesia time should reflect only the cumulative time the anesthesia provider is physically present in providing anesthesia care to the patient.**

The Physician Payment Review Commission (PPRC) in its Annual Report to Congress, 1991 also disagreed with the GAO recommendation to eliminate time units. The PPRC supported the continued use of actual time units, along with better verification procedures. The specific PPRC recommendation stated: "Medicare should continue to pay for anesthesia services on the basis of base units and actual time. It should develop a more rigorous definition of anesthesia time and implement procedures to validate the time of anesthesia

services. The hospital or surgical center should be responsible for verifying anesthesia times."

The alternative payment methodology that HCFA proposes is the use of average time unit values. The AANA does not support this option for the following reasons:

- It would create administrative problems in institutions where the speed of the surgeon varies from practitioner to practitioner. Anesthesia providers would have a financial incentive to opt to work with the faster surgeons.

- This option may systemically reduce payments to CRNAs who work in teaching hospitals and smaller rural hospitals where surgeries may take longer.

- At minimum, an averaging approach would need to include some type of outliers to accommodate the factors that are outside the anesthesia provider's control.

The elimination of anesthesia time would be a significant departure from current practice, that is unwarranted merely to have anesthesia payment methodology conform to that used for other physicians' services. Administrative convenience is an insufficient rationale for such a major policy change. We believe that a clarification of the definition of anesthesia time will obviate the need to develop an alternative payment methodology for anesthesia time. We acknowledge that it may be necessary for anesthesia services to have a separate conversion factor (CF) if we retain the use of time in determining payment. We do not oppose having a separate anesthesia CF. Alternately, the AANA would be willing to work with HCFA to develop another appropriate methodology, such as an adaption to the work component, that would allow the standard CF to still be used.

Use of Same Relative Value Scale for CRNAs and Anesthesiologists

CRNAs providing services to Medicare beneficiaries have been paid under the URVG for over two years now, and have found it to work very well. Therefore, the AANA agrees that HCFA should use the same relative value scale for anesthesia services furnished by anesthesiologists and CRNAs. HCFA's rationale for doing so is that it would be simpler for CRNAs, physicians, hospitals, and carriers. AANA concurs with this rationale but, but more importantly, we believe that different relative values or conversion factors should not be used for a health care providers' service based on whether the health care provider furnishing the service is a nonphysician or a physician.

CRNA Payment Not to Exceed Anesthesiologist Payment

The proposed rule accurately reflects the legislative history of the new CRNA CFs mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA90). Although the specific OBRA90 statutory language required that the CF used for non-medically directed CRNAs should not exceed the CF used for anesthesiologists, congressional intent was clearly that the CF for non-medically directed CRNAs and the CF for medically directed CRNAs should not exceed the CF for an anesthesiologist who personally performs an anesthesia service in the same locality.

Having stipulated that, however, the AANA does not believe that there needs to be an adjustment factor applied to the payment amount for non-medically directed CRNA services to assure that payments are not in excess of the payment for a personally performed anesthesiologist procedure. The simplest and most logical way to prevent excess payment to non-medically directed CRNAs is to require them to use the proposed AA modifier to the CF

for a personally performed anesthesiologist procedure in that locality, with an additional modifier of "N" to signify non-medically directed CRNA. The addition of the "N" would result in the non-medically directed CRNA rate being paid at the same rate as the anesthesiologist, but it would clarify that a non-medically directed CRNA had performed the anesthesia service.

We would then suggest that a medically directed CRNA in that locality use the proposed "AA" modifier with an additional modifier of "M" to signify a medically directed CRNA. The addition of the "M" modifier would result in the non-medically directed CRNA's payment level being multiplied by 70 percent, which is the rate for medically directed CRNAs that was agreed to in OBRA90.

Page 25808, column 2, through 25811, column 2: Anesthesia Services

The AANA will address four issues referenced in this section: method for integrating anesthesia services into the fee schedule, payment for specialized services, monitored anesthesia care, and teaching anesthesiologists.

Method for Integrating Anesthesia Services into the Fee Schedule

We have serious concerns with the use of the cross linking method HCFA is proposing because it does not take into account the previous payment reduction that anesthesiologists have already received. OBRA90 mandated that the weighted national average CF for anesthesiologists be reduced by seven percent, effective January 1, 1991. This reduction has not been factored into the baseline used to determine the remainder of the reductions to be made in anesthesiology services.

Payment for Specialized Services

The AANA agrees with the decision to allow separate payment for specialized procedures when these procedures are furnished in conjunction with an anesthesia procedure or as an unrelated procedure. In that virtually all carriers permit separate payment for these services when furnished by nonanesthesiologists, equity demands that anesthesiologists also be reimbursed for these services. In that same vein, equity also requires that CRNAs be reimbursed for these services as part of their integration into the physician fee schedule.

The Omnibus Budget Reconciliation Act of 1986 clearly established coverage and direct payment under Medicare Part B for anesthesia services and related care furnished by a CRNA. Unfortunately, in the January 1989 proposed rule implementing the Medicare CRNA fee schedule, HCFA incorrectly concluded that there was no need to recognize separate payments for related services performed by CRNAs. AANA strongly disagrees with HCFA's treatment of CRNAs with regards to related services because it is inconsistent with its policy for other health care providers.

AANA believes there should be a separate payment for "related services" for all providers for the following reasons:

- Many "related services" such as intubations and arterial lines are provided for patients that are not surgical patients. In fact, some CRNAs provide nothing but the aforementioned services, and therefore, their entire salary is based upon revenues generated from providing these services.

- Frequently the reason for invasive monitoring is not only for intraoperative management, but is also done at the request of physicians for purposes of post-operative management.

- We believe that if a pre-anesthetic initial evaluation/consultation is done by a CRNA and the surgery is not performed, the evaluation/consultation should be paid for separately, i.e. as a related service.

The AANA applauds HCFA's decision to not bundle payment for specialized procedures into the anesthesia payment, but rather to allow separate payment for the services. If anesthesiologists and other physician providers are paid separately for "related services", then CRNAs who provide the same services should not be discriminated against in the provision of payment. Hopefully, HCFA has been consistent in its policies and has incorporated similar payment for specialized procedures in the final CRNA fee schedule that has been approved by Administrator Wilensky and awaits approval by HHS Secretary Louis Sullivan and the Office of Management and Budget.

Monitored Anesthesia Care

The AANA opposes the development of a uniform modifier to be used with the anesthesia code to identify monitored anesthesia care (MAC). We believe that there is no longer any reason to distinguish between anesthesia provided by nerve block, intravenous, or inhalation technique for purposes of Medicare payment. The proposed rule erroneously implies that any anesthetic that is not a general anesthetic is monitored anesthesia care.

The procedural physician, often in consultation with the CRNA or anesthesiologist, determines whether a patient would benefit from anesthesia. Once that decision has been made, it is the patient's needs that determine whether a general anesthetic, regional anesthetic, local anesthetic, or conscious sedation should be administered. Several years ago, HCFA decided to eliminate payment for "local standby", which had allowed an anesthesia provider to be reimbursed for being on call in case there was a need to administer an anesthetic during a procedure. HCFA was concerned that the anesthesia providers were being paid for "local standby", when they may never have entered the room while the case was in progress. When payment for "local standby" was eliminated, it was replaced with the concept of MAC. The notice references the Office of Inspector General's report entitled "Medicare Coverage and Reimbursement for Monitored Anesthesia Care". The AANA does not concur with the report's implication that the current policy of paying the same amount for MAC and general anesthesia is inappropriate. We believe that the current MAC payment policy is appropriate for these reasons:

- The preparation of the patient and equipment is identical.

- The technical skill of the anesthesia provider is the same.

- MAC cases frequently involve patients who are too sick for general anesthesia, so the patient acuity is higher.

- Anesthesia providers do not determine who monitors the patient, the surgeon does.

- While 20 percent of surgical cases are done under local anesthesia, it is only the more seriously ill patients that get monitored. If MAC is not medically necessary, then carriers should exercise their right to not pay for it.

- The fact that there are not regular and frequent complications associated with MAC cases is a result of the patient education, patient selection, monitoring, and skill of the anesthesia provider, not because there wasn't a need to monitor.

- The use of MAC emphasizes prevention first, consequently there is often no need for vasopressors, IVs, hospitalization, or high cost anesthesia equipment and supplies utilized during general anesthesia.

- MAC makes the use of local and regional anesthesia possible in outpatient surgical settings, rather than necessitating the use of general anesthesia in an inpatient setting.

- Patients receiving potent tranquilizers, sedatives, and narcotics require close monitoring by qualified anesthesia providers to ensure quality care, to prevent serious complications from occurring, and to allow the procedural physician to focus on the procedure itself.

If HCFA is concerned about anesthesia providers billing for MAC when they are not actually with the patient, we submit that the tightened definition of anesthesia time that the AANA has proposed should obviate the need to develop a MAC modifier. The anesthesia time should reflect only the cumulative time the anesthesia provider is physically present in providing anesthesia care to the patient.

The AANA is very concerned that HCFA may be intending to use data obtained from requiring a MAC modifier to justify a decrease in payment for MAC. We firmly believe that the decision regarding whether to provide general anesthesia, regional anesthesia like an epidural block for a woman in labor, local anesthesia, or conscious sedation should be made based on individual patient needs and not for financial reasons. It is not good public policy to create a situation where the patient has to be put to sleep in order for an anesthesia provider to receive payment for their service.

Teaching Anesthesiologists

The AANA applauds HCFA's decision to remove the financial incentive for a teaching anesthesiologist to choose an anesthesiology intern or resident over a CRNA. We agree that there should be a consistent medical direction payment policy for concurrent procedures, regardless of whether they involve interns, residents, CRNAs, or student nurse anesthetists. Medicare carriers currently allow full base units and 15-minute time units for physician concurrent medical direction of up to two anesthesiology residents. However, the lack of an official HCFA policy on payment for teaching anesthesiologist or CRNA direction of nurse anesthesia students has led carriers to uniformly deny payment for the concurrent direction by a teaching anesthesiologist or CRNA of up to two nurse anesthesia students. While we are pleased that HCFA has proposed to remedy the current inequity between anesthesiology residents and CRNAs, we are concerned that the HCFA proposal does not deal with the fact that anesthesiology residents and nurse anesthesia students are also being treated differently.

However, we are hopeful that the disparity between anesthesiology residents and nurse anesthesia students will be changed by HCFA in the final CRNA fee schedule rule. In a June 15, 1990 memo from Charles R. Booth, Director, Office of Payment Policy, BPD, HCFA, to the Associate Regional Administrator for Medicare, Atlanta, Mr. Booth stated in relevant part that, "We are considering, in the final CRNA regulations, the adoption of a policy that would recognize medical direction whenever an anesthesiologist medically directs concurrent procedures involving student nurse anesthetists. It is our position that if State law does not prohibit the student nurse anesthetists from administering anesthesia, then the carrier can recognize medical direction payment prospectively. If it is not clear that North Carolina State law does not impose a prohibition, the carrier or your office might wish to obtain a legal opinion from the State's Attorney General Office." If the approach that HCFA ultimately adopts is to reduce payments for concurrent medical direction regardless of who is directed, we strongly recommend that it be applied across-the-board to anesthesiologists and CRNAs who also work with nurse anesthesia students.

The AANA appreciates the opportunity to have our comments on the fee schedule considered.

STATEMENT OF THE AMERICAN COLLEGE OF NUCLEAR PHYSICIANS
AND THE
SOCIETY OF NUCLEAR MEDICINE

We appreciate this opportunity to present our initial assessment of the proposed Medicare Fee Schedule (MFS) to the House Ways and Means Subcommittee on Health. The American College of Nuclear Physicians (ACNP) and the Society of Nuclear Medicine (SNM) represent approximately 14,000 physicians, physicists, radiopharmacologists, and technologists who specialize in the use of radioisotopes in medicine. Nuclear medicine procedures are an integral part of the management of diseases, such as cancer and heart disease, that afflict our older patients.

Our impressions are that the proposed MFS, which for imaging specialists will result in an unwarranted 52% reduction in fees, was driven by budgetary considerations and unmindful of the impact on medical practice in this country. The proposed fees for our most common procedures in the Medicare population (78306 -bone scan imaging, 78481 - cardiac function, 78461 - thallium heart stress test, and 78585 - lung imaging for clots) are all lower than paid under Medicaid. The proposed fee for thyroid imaging, a procedure not unfamiliar to the Administration's First Family, is less than twenty dollars. By professional fee reduction alone, the proposed MFS may preclude the provision of nuclear medicine procedures in all but urban areas and in multispecialty imaging practices.

There are uncertainties in the derivation of costs of, as well as application of, the proposed Technical Component of the MFS; the results may restrict the provision of nuclear medicine. For example, the actual technical cost of doing a bone (78306) imaging study in 1985 (ACNP Analysis of Nuclear Medicine Cost Survey) ranged from $125 - $205 in private practice and from $115 - $334 in academic hospitals; and yet the proposed MFS would pay only $123.15 eleven years later in 1996!

The ACNP and SNM are uncomfortable even as we write our detailed response to the Health Care Financing Administration (HCFA) about the proposed MFS, because we have no results from the Phase II Hsalo study on nuclear medicine insisted upon by Congress, have no data from HCFA about the cross-link vignettes used in amalgamating the radiology relative value scale with the resource based relative value scale, and are unaware of any nuclear medicine participation or results from Phase III. In other words, we feel that we have insufficient information to answer many questions.

HCFA has proposed that the cost of diagnostic and therapeutic radionuclides be designated as a separately identifiable technical component, and that the prices be set locally. We ask the Subcommittee to consider legislation to require uniform application by HCFA of decisions about costs of such substances through out the country, and not leave it to 270 separate jurisdictions. Currently there is not even a uniform approval of one Medicare payor to another of accepted procedures. We do not have confidence that there will be any better result in the establishment of fees to pay for the radiopharmaceuticals which are critical to providing medical care.

The ACNP and SNM strongly support the stance of the American Medical Association on the unfairness of the proposed reduction in the conversion factor by the Asymmetrical Transition and Behavioral Offsets. Obviously from our perspective as a medical specialty to whom patients are referred, our practice reflects the utility of what other physicians consider it to be. The Behavioral Offset is disparaging of our profession as a whole. Lacking evidence, we trust that Congress will be able to convince HCFA to drop it.

We completely concur with the American College of Radiology in its dismay at the Administration proposing such extreme fee reductions on imaging after the agreement with Congress that has already resulted in a voluntary 20% reduction in fees over the past several years! This had an even greater effect on nuclear medicine than perhaps some other areas of imaging. Congress passed a special rule which acknowledged nuclear medicine's concerns about the radiology fee schedule and set a specialty differential for nuclear medicine. We ask that Congress assure that the reasons for that differential be incorporated into the final MFS.

In summary, the nuclear medicine community joins the medical community at large in its hope that Congress will help rectify the budget driven proposed MFS. We support the ideals behind the resource based relative value system, including the expectation of equitable compensation of all physicians. What has been proposed will not accomplish that, and we fear an adverse impact on the provision of medical care. We will work with Congress and the Administration in implementation of this major change in medical practice, but are concerned that time will not permit reasonable and rational answers to the problems in the proposed MFS. Considering the ambiguity and uncertainties in the proposed MFS, we urge the House Subcommittee on Health to consider the start of the 1993 fiscal year rather than January 1, 1992 as the commencement date.

STATEMENT OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

The American College of Rheumatology (ACR/the College) is pleased to provide a statement to the Subcommittee Health, Committee on Ways and Means on Medicare payments to physicians under the resource-based relative value scale (RBRVS) especially in light of the Administration's recently proposed rule which translates the RBRVS into a Medicare Fee Schedule for physician's services.

The ACR is the world's largest organization of rheumatologists, both physicians and scientists, dedicated to the prevention, treatment and eventual cure of arthritis and the more than 100 types of rheumatic diseases.

The College endorse Chairman Stark's and the Subcommittee's commitment to identify and resolve the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a fair and equitable Medicare Fee Schedule. The College will provide comments to HCFA on several areas of concern, but will focus our comments on the two most problematic – the reductions to the conversion factor, and HCFA's estimations of practice costs.

Reductions in the Dollar Conversion Factor:

The proposed rule mandates a drastic, unnecessary and unanticipated reduction in physician fees of over $12 billion by 1996, due to conversion factor reductions of 16 to 22 percent. This contradicts Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting devise. Rheumatology, a specialty that provides primary care for many patients and is unique in its case mix and overhead costs, will face an inappropriate reduction in physician reimbursement as a consequence of the unanticipated conversion factor reductions. It is because of these reductions to the dollar conversion factor, that physician payments to rheumatologists and others will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained by OBRA '89, and therefore we call upon the Congress to correct them through legislative action. Congress should also mandate HCFA to reverse the remaining unnecessary reductions to the dollar conversion factor which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

Behavioral offset adjustment: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4.5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

The College maintains that no behavioral offset be assumed by HCFA because we believe that the Volume Performance Standards will compensate for any volume increase. In the unlikely case that the VPSs do not take care of all unanticipated volume increases, Congress could recommend greater reductions in updates, or change the default formula. Furthermore, scientific data supporting the concept of a behavioral offset are not well developed nor uniformly accepted by the Congressional Budget Office (CBO) and the Physician Payment Review Commission (PPRC). HCFA, CBO, and the PPRC all admit uncertainty as to physician responses to the new payment system, and the lack of substantial data on the subject (even the most relevant data employed by HCFA on this issue (Christensen)) is severely limited – it is outdated (1976), only general practitioners and internists were studied, the data was gathered from a single state, etc. Until such data are validated, we strongly urge Congressional legislation prohibiting HCFA from employing a behavioral offset assumption its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

Transition rules adjustment: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made. However, HCFA staff now explain that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6.2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

Crosswalk to the new visit codes: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

Summary of HCFA's conversion factor reductions:

-10.5%	behavioral offset -- no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment -- $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone -- $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk -- no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF -- would translate into over $12 billion (plus additional cuts due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS. These data are in direct contradiction to Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. The College urges Congress to enact legislation that will return physician payment reform to a budget neutral basis which was the initial intent. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further reduce the conversion factor.

The College understands and supports the pay-as-you-go budget rules passed last year. However, we cannot stand by and watch physician payment reform be destroyed. Technical drafting errors should not be used to call these rules into force. The College would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

Practice Expenses:

The College is opposed to basing the computation of practice expense relative value units (RVUs) on the current charged-based system. Although, HCFA is following the statute in this area, the current formula is highly inequitable to rheumatologists and other office-based physicians, and is

not consistent with an overall resource-based approach to physician payment reform. The College strongly recommends that Congress amend OBRA '89 to base practice expense relative values on estimates of resources used, rather than on historical charges. This recommendation has the support of the Physician Payment Review Commission.

There are several reasons why using the charged based system for estimating practice expenses is inequitable to rheumatologists and other physicians. Under this system, the amount rheumatologists are paid for a given service is influenced by the historical charge levels and the averaging of practice expense shares of all the other physicians who most often perform the service, rather than by the actual resource costs involved in providing the service. Because historical charge levels cannot be explained by the actual input costs of providing a service, it is unlikely that those charge levels will lead to accurate payment for practice costs. In addition, while rheumatologists are few in number, it is clear that the averaging plan will result in total relative value units which are too high for all other physicians who provide the services most often and too low for rheumatologists. This will increase reimbursement for all physicians and decrease reimbursement levels for rheumatologists. Lastly, since rheumatology is not recognized by HCFA as a distinct specialty, we are not listed separately in the data presented by HCFA in the proposed rule for the purposes of calculating the percentage of mean total revenue that goes to overhead and medical liability. Rather, we are lumped in with internal medicine. This lack of specialty recognition by HCFA has caused numerous problems for rheumatologists in other areas as well. Without specialty recognition, it is impossible to identify the true impact of the averaging plan.

In keeping with the intent of a resource-based relative value scale, the Harvard study constructed a practice cost index value for each specialty to ensure practice cost reimbursement levels were fair and equitable. The OBRA '89 methodology for practice costs challenges the construct and philosophy of the Harvard study and physician payment reform because it is (1) not resource-based; and (2) does not allow for the differences in practice costs of all specialties. This is particularly troublesome for rheumatology because averaging practice costs across all physicians would put rheumatology at a significant disadvantage when compared to family physicians and internists who provide the greatest portion of evaluation and management services with lower overhead costs. According to the Harvard study, "Relative Cost Differences Among Physicians' Specialty Practices" (*JAMA*, October 28, 1988), practice costs for rheumatologists were higher than any of the other medical specialties studied with the exception of orthopedics. The study also stated that "the range of relative differences in practice costs among most specialties as a percentage of gross revenue is approximately 15 percent."

It is clear that HCFA's averaging plan is unfair to rheumatology, both because it is not resource based, and because it does not consider the higher overhead costs incurred by rheumatologists. Rheumatologists should be appropriately compensated for the extra resource costs involved in providing services to beneficiaries. The College urges the Congress to replace the OBRA '89 methodology for estimating practice costs with one that is resource-based, and mandate that HCFA employ separate calculations for overhead for rheumatology since we have higher overhead costs than most other medical specialties. Congress should encourage HCFA to return to the original Harvard data on practice costs. With this, we will move more fully toward addressing the issues which prompted a change in physician payment in the first place.

STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA), and its 53 constituent state and territorial nurses associations, is pleased to have this opportunity to present its views on the Medicare fee schedule for physician services and its impact on registered nurses and nurses in advanced practice.

The American Nurses Association represents the nation's two million registered nurses including nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists.

Nurses in Advanced Practice

Our comments will focus on nurse practitioners and clinical nurse specialists who are independent providers of Medicare services to beneficiaries. The Medicare Fee Schedule will have a direct impact on the ability of these nurses to provide services to beneficiaries in rural areas and in nursing facilities. We would like to review the services provided by these two groups of advanced practice nurses as well as their education, training and the locations where they practice.

Nurse practitioners are registered nurses prepared through a formal, organized education program for an advanced practice role that meets the guidelines established by the nursing profession. The majority of their training and education is in the area of primary care. They receive the advanced education and clinical training either in a certificate program or a master's program. Certificate programs are at least one year in length and are followed by a period of supervised clinical practice. Almost 50 percent of nurse practitioners are educated at the master's level. All nurse practitioners must meet requirements for certification in their area of specialty. By 1992, the ANA will require all nurse practitioners to be educated at the master's level in order to meet the requirements for certification. There are currently approximately 25,000 nurse practitioners nationwide.

Nurse practitioners provide primary health care that includes traditional medical services, as well as nursing care. The primary health care services encompass the identification, management and/or referral of health problems, the promotion of health maintaining behavior and the prevention of illness. It is their health care delivery approach that takes into account the needs and strengths of the whole person.

Nurse practitioners are able to deliver independently the majority of primary care services. Several studies have shown that 60 percent to 80 percent of primary care services traditionally provided by physicians can be provided by nurse practitioners. (Hausner, 1983 and Record, 1980).

Nurse practitioners are found in almost every health care setting: clinics, hospitals, schools, businesses, nursing homes, HMOs, college campuses, prisons, day care centers and in private practice. They also provide health care services in settings where physicians are not available such as rural and inner city areas, and to Medicare beneficiaries, such as the disabled, poor, minorities and residents of nursing homes, who otherwise might have no access to care.

A clinical nurse specialist is a registered nurse (RN) who, through study and supervised practice at the graduate level (Masters or Doctorate), has become an expert in a defined area of knowledge and practice in a selected area of clinical nursing. The clinical nurse specialist must have earned a graduate degree that represents study and advanced clinical practice related to the specialty.

The role of the clinical nurse specialist is multi-faceted, including clinical practice, education, consultation, research and administration. Clinical practice includes direct care to selected clients and families in practice areas such as oncology, rehabilitation, psychiatric and mental health, pediatrics, specialized acute, medical, surgical and gerontology.

Clinical nurse specialists are similar to nurse practitioners in that they deliver primary health care in the community, in settings such as outpatient clinics, HMOs, home health agencies and in private practice, as well as delivering care to the elderly and disabled in long-term care facilities.

Clinical nurse specialists must be certified or meet requirements for certification by the profession. This credentialing provides a safeguard to the consumer who has evidence that the RN is a specialist at the advanced level of clinical practice. There are currently approximately 16,000 clinical nurse specialists nationwide.

Both nurse practitioners and clinical nurse specialists are trained not only to provide substitute services for physicians, but also to provide the additional support, patient education and preventive services that physicians generally do not provide.

Medicare Fee Schedule for Physician Services

Conversion Factor Calculations. The American Nurses Association is surprised and extremely concerned about the effects that the conversion calculations described in the notice of proposed rule making (NPRM) would have on payment levels under the new Medicare fee schedule. In our judgment, the Health Care Financing Administration (HCFA) has gone much too far in using the concepts of "transition asymmetry" and "behavioral offset" to achieve major Medicare budgetary goals, instead of legitimate practitioner payment reforms. As a result, much of the long-expected reform in the values for cognitive and procedural services will simply not be realized under the severe assumptions used in calculating the conversion factor. These calculations, of course, will affect payments for all services affected by the new plan, including the services of nonphysician providers.

Services "Incident" to a Physician's Service. The ANA supports the intention of HCFA to continue the payment of services under the "incident to" rules. This rule allows payment for the services delivered by registered nurses that are commonly furnished as part of, and billed for as, a physician's service. Such rules allow for the efficient provision of patient care services by physicians and nurses working together in a collaborative manner, and reflect the fact that a "physician's service" often includes the services of other health professionals.

ANA recognizes, however, that under payment reform, further steps may be needed to refine the "incident to" rules to more accurately identify the extent and type of services provided by some nonphysician providers, including the services of nurses in advanced practice, such as nurse practitioners and clinical nurse specialists. Thus, ANA also supports HCFA's plans to use coding modifiers to gather this type of information under the payment reform plan.

Payments for the Services of Nonphysician Providers (NPPs). Beginning on January 1, 1992, payments for the covered services of certain nonphysician providers (NPPs) will, in general, be limited to the lowest of the actual charge, the reasonable charge, or a specified percentage of the new physician fee schedule for such services. For example, the services of a nurse practitioner furnished in a skilled nursing facility will be limited to 85 percent of the new fee schedule amount effective January 1, 1992, and by other percentages of the fee schedule amounts applicable to covered services furnished in rural areas.

The NPRM takes note of the fact, however, that recommendations for changing the current NPP payment rules were recently submitted by the Physician Payment Review Commission (PPRC) in its 1991 Report to Congress. In its Report, the PPRC states the view that payments for NPPs should be based on resource costs, using the same resource-based methodology that was used to develop payments or physicians' services under the new Medicare fee schedule. In general, the ANA supports this recommendation with some important modifications, and hopes that at the earliest opportunity Congress will examine ways to make payments for NPP services more consistent with the overall goals of payment reform for all practitioner services.

Physician Payment Review Recommendations on Payment to NPPs

ANA is supportive of many of the recommendations made by the Physician Payment Review Commission (PPRC), however some fall short of ANA's goal to have services

provided by nonphysician providers recognized and valued the same as when provided by a physician. While the recommendations are a major step toward controlling the cost of health care, the proposal is flawed in that it would not pay nonphysician providers equally for services they perform that are the same as those provided by a physician. In addition, equitable payment levels for nonphysician providers would provide benefits for consumers who would have increased access to health care services, another goal of ANA.

The Medicare fee schedule for physician services is based on the principle that Medicare is paying for a service, not a credential. Thus, when physicians perform the same service, they will be reimbursed at the same level, regardless of their level of training. Unfortunately the Commission fails to apply this same principle to the services provided by nonphysician providers when they substitute for a physician.

ANA's specific response to the PPRC's recommendations on payment levels for NPPs are as follows:

* **The ANA agrees with the PPRC recommendation that the payments for NPPs be based on resource costs.** ANA has concerns with the logic and science utilized by the Commission when they assert the premise that payments for NPP services should be different than those of physicians. "Current percentage differentials, however should be replaced with differentials that reflect differences in physicians' and nonphysicians' resource costs: work, practice expense, and malpractice expense."

* **Work Component.** The PPRC recommends a different valuation standard for services performed by NPPs than it recommends when those services are provided by physicians. They recommend that the work component reflect differences in education and training costs between each NPP category and physicians. The Commission rejected the use of an education and training factor in setting values for services provided by the different physician specialties. In addition, the Commission arbitrarily reduces the work values for NPPs even further through a methodology that fails to fairly compare NPPs with physicians for whom the NPPs are alternative providers of Medicare services. **The ANA strongly objects to this recommendation as inconsistent with the underlying principles of the resource based relative value scale, and that the Commission's proposals are inequitable and discriminatory.**

* **Practice Expense. The ANA supports the Commission's recommendation that the "practice expenses for a type of service should be roughly the same whether it is provided by an NPP or a physician" and that the practice expense component should not be differentiated in setting NPP payments.**

* **Malpractice Expense. The ANA supports the Commission's recommendation that the differences between the NPPs' and physicians expenses for malpractice insurance be reflected in the fee schedule.** The ANA believes this is consistent with the resource based relative value scale (RBRVS) principle.

* **The ANA agrees with the Commission recommendation that NPPs receive the same bonus payments that physicians receive in health professional shortage areas (HPSAs).**

The ANA believes that the Commission's recommendations provide a framework for inclusion of NPP services in the new Medicare fee schedule using a common resource-based approach to payment for those services. The ANA recommends that the work component of the fee schedule for NPPs should differ only if the service is different and should not differ based on training and education costs. Since there is no evidence to suggest that similar services delivered by NPPs and physicians are different in value, then the value of the work component should be the same. In fact, the Rural Health Advisory Council has recommended that actual payments to NPPs be the same as to physicians in order to increase access to health care in rural areas.

The ANA would welcome the opportunity to discuss our views on this issue in more detail with the Members of the Subcommittee. In addition, we look forward to working with the Subcommittee as the issues of health care cost containment and the provision of quality care are addressed.

TESTIMONY OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman, the American Psychiatric Association, a medical specialty society representing more than 37,000 psychiatric physicians nationwide, appreciates this opportunity to present testimony on our analysis of the impact of the new Medicare Fee Schedule (MFS) for physician payments proposed on June 5, 1991, by the Health Care Financing Administration (HCFA).

As you know, the underlying premise of physician payment reform through the Resource-Based Relative Value Scale (RBRVS) -- on which the MFS is based -- is that "intrusive services" (mostly surgical) are overvalued relative to "cognitive services" (such as psychiatry) under existing Medicare payment rules. Certainly, Congressional intent for the new physician payment schedule was that the MFS was expected to redistribute Medicare payments such that payments for cognitive services would increase.

We believe that among medical specialties it is not disputed that psychiatry is the epitome of a "cognitive" medical specialty. Thus, the APA had reason to believe that reimbursement for psychiatric services under the new MFS would increase or, at worst given "budget neutrality" requirements imposed by the Congress for 1992, be unchanged compared to current reimbursement levels.

Yet the MFS developed by HCFA nets to an inexplicable 9% reduction in payments per service for psychiatric services in the first year of implementation of the MFS, and to a 5% reduction over the full five year phase-in of the MFS. Our concern about this outcome is compounded by the fact that the first-year 9% reduction for psychiatry is the largest payment reduction for any medical specialty under the MFS, including surgical specialties. Even HCFA's own actuaries cannot explain this result.

The APA believes that the HCFA MFS for psychiatry is seriously flawed. We are concerned that the impact of the MFS on psychiatry is so adverse that there may be a substantial impact on patient access to care. As does a broad spectrum of medical professional organizations, we also take strong exception to the impact of the $3 billion behavioral offset which HCFA has proposed and developed.

Also, we note that because time is a non-variable for most psychiatric services, psychiatrists cannot "compensate" (as the behavioral offset assumes all medical specialties will attempt) for fee reductions by increasing either intensity or volume of service. However, HCFA's behavioral offset compounds the impact of what we believe to be the underlying flaws in the HCFA proposed MFS for psychiatry.

The proposed MFS as published in the Federal Register provides just 60 days for comment, the final rule will be published in October 1991, and the MFS will become effective on January 1, 1992. As our testimony will outline below, we believe that the data and methodology used to develop the MFS as published on June 5 is sufficiently suspect that we find it virtually impossible to make substantive comments which will have real bearing on the final rule.

In effect, we are being asked to comment on a proposed rule for psychiatry which, we believe, has no basis in fact. Until HCFA can explain to us the methodology used to develop the MFS for psychiatry, we cannot even begin to verify where the errors in their data and methodology may have occurred. We note that HCFA staff have informally acknowledged to us that they cannot explain why the MFS is so adverse for psychiatric billing codes under Medicare and that there may well be problems with the data used to develop the MFS for psychiatry.

As noted, we believe that there are substantial statistical and methodological errors in the HCFA MFS. These include:

1. Errors in HCFA's use of the Medicare Part B (BMAD) data to develop the fee schedule conversion factor.

2. Collateral errors in the BMAD data and its use which devalue the office practice and malpractice components of the final Fee Schedule reimbursement for psychiatric billing codes.

3. Unexplained HCFA changes to the Hsiao relative work units assigned to psychiatric billing codes.

4. Fundamental problems in the cross specialty time links which equate fifty minutes of psychotherapy with, for example, draining of a finger abscess.

5. Devaluation of actual current psychiatric reimbursement by HCFA's apparent use of BMAD data showing average allowed charges as opposed to some other more appropriate statistical measure.

6. Failure to adjust the Fee Schedule for the fact that, for psychotherapy, time is a highly significant non-variable component of service.

7. Failure of Current Procedural Terminology (CPT) codes to properly capture psychotherapy work components.

8. Unspecified -- and, we believe, unauthorized -- use of Phase III Hsiao RBRVS work in the proposed MFS. We have not seen the Phase III work and have had no opportunity to verify it or comment on it.

Since HCFA has released neither the data on which the MFS was based, nor the methodology for the Fee Schedule in general or for psychiatry in particular, our analysis must be viewed as preliminary. Indeed, we stress that we are particularly frustrated that we cannot provide greater specificity of analysis because of the complexity of the MFS and the lack of hard data provided by HCFA on which to base our comments.

Nevertheless, our analysis to-date of major problems is as follows:

1. **HCFA has Disregarded Time in Setting Work RVUs:**

The most troublesome problem with the new MFS appears to be a general discounting of the importance of time in establishing relative values for psychiatric services. As evidence of this, the APA submits the following examples:

- The first example can be found by comparing two Current Procedural Terminology (CPT) codes, 90844 (individual psychotherapy for fifty minutes) and 26011 (drainage of a finger abscess) both of which have nearly the same Work Value Unit (RVUs). Clearly the time it takes a physician to treat a finger abscess is significantly less than fifty minutes, the time required to perform individual psychotherapy. Thus, it is not credible that these two physician services, if time is any factor in performing a procedure, are valued to be equal in work in the proposed Medicare Fee Schedule.

  In addition, other short duration procedures -- for example, 36489 (insertion of a catheter, vein), and 27648 (injection for an ankle X-ray), have work RVUs similar to the fifty minute psychotherapy procedure. We believe that these services do not compare in time with that inherent in the 90844 psychotherapy procedure nor are they time "driven."

- The second example is the work RVUs assigned to 90853 (group medical psychotherapy). CPT 90853 may consist of either sixty or ninety minutes of therapy, however, only one work RVU is presented for this service in the proposed Medicare Fee Schedule. Certainly, we believe that HCFA should not intend to value a sixty minute therapy session equally with that of the ninety minute session. The same point can be made with CPT 90847 (family medical psychotherapy - conjoint).

2. **Failure of CPT Codes to Capture Psychotherapy Work Components:**

The psychotherapy RVUs fail to acknowledge that psychotherapy is actually a unique blend of several procedures, including on-going diagnosis, evaluation, management, and treatment; however, the current CPT coding system fails to capture the full range of tasks comprised in a psychotherapy visit. Psychiatrists, unlike other physicians, do not have a multiplicity of CPT codes that reflect all aspects of the specific services they provide during an "office visit." To the extent that current CPT codes do not adequately capture the work that is performed by psychiatrists, the use of CPT codes for the new Fee Schedule will inherently and inappropriately skew final reimbursement under the Fee Schedule downward for psychiatric CPTs.

Moreover, HCFA cannot assert that the failure of current CPT coding to accurately reflect the work performed by psychiatrists is outside the scope of HCFA's appropriate value-setting authority. The June 5th NPRM is replete with comments about reconfiguration of office visit descriptors with time considerations as part of the HCFA MFS such as, for example, in bundling EKG interpretation values into certain visits.

3. HCFA's "Behavioral Offset" is Inequitable for Psychiatry:

APA believes the the apparent disregard for time in calculating work RVUs affects psychiatry more than any other physician specialty because our services are historically and inextricably bound to time considerations.

The disregard for time is compounded by the behavioral offset HCFA has proposed to ensure budget neutrality in 1992. In essence, the behavioral offset is a hedge against under-compensation for physician response to the fee schedule in the first year of phase-in, since it assumes that physicians will respond to reduced reimbursement by increasing volume or intensity of service at a rate which requires adjustment for budget neutrality.

While we are troubled by this non-scientifically supported allegation, we are even more troubled by HCFA's failure to appreciate that not all physicians or physician services can respond in this fashion. As we have noted, most psychiatric services are highly time dependent. As a result, psychiatrists, for example by their most used CPT Code (90844), cannot respond to the fee schedule by increasing time or intensity of service in a way which would justify the behavioral offset under HCFA's behavioral offset proposal.

Put another way, time may be a relatively inconsequential variable for other procedures, but it is a significant constant for psychotherapy. We cannot, for example, perform two fifty minute psychotherapy sessions in a single hour. Accordingly, we believe that the behavioral offset for psychiatry is unfounded and should be eliminated.

4. HCFA Modification of the Hsiao Phase II Work RVUs:

We believe that HCFA has modified the Hsiao Phase II work RVUs for psychiatric services. APA believes that this modification may be in error.

We identified this apparent problem by rank ordering the Hsiao Phase II and HCFA proposed Medicare Fee Schedule work RVUs for psychiatric services. Upon comparing these two rank ordered lists -- excluding any consideration of practice and malpractice cost RVUs -- the HCFA rank ordering does not parallel the Hsiao Phase II rank ordering of psychiatric service work RVUs.

As evidence of this, we cite the following examples:

- CPT code 90801 (a diagnostic interview, exam) was valued at 175 work RVUs and CPT code 90847 (family medical psychotherapy - conjoint) was valued at 212 RVUs in the Hsiao Phase II work. According to the proposed Medicare Fee Schedule, however, 90801 is valued at 1.98 RVUs and 90847 is valued at 1.97 RVUs. Not only have the rank order positions of these two codes changed, their respective work RVUs are almost equal to one another in the proposed Medicare Fee Schedule as contrasted with that established by the Hsiao Phase II rank ordering.

- CPT code 90853 (group medical psychotherapy) was valued at 199 work RVUs by the Hsiao Phase II work for a sixty minute session but only .34 by the proposed Medicare Fee Schedule.

- The same question can be raised about CPT code 90847 (family medical psychotherapy - conjoint with sixty and ninety minute versions). The proposed HCFA work RVUs for 90853 and 90847 substantially changes the rank ordering of these CPT codes relative to other psychiatric services, but more importantly they represent a drastic devaluation of group psychotherapy and family psychotherapy. APA believes it reasonable to have a complete explanation from HCFA of the proposed work RVUs for 90853 and 90847, and all other psychiatric codes.

5. There are Numerous Questions Surrounding HCFA's use of BMAD Data:

HCFA "aged" BMAD data in order to project Medicare Part B outlays for 1992. As you know, the 1992 Medicare Part B outlay projection is of critical importance due to the statute requiring budget neutrality of the new RBRVS Medicare Fee Schedule during its first-year implementation. APA believes that significant errors are present in the BMAD data or in HCFA's use of the data pertaining to psychiatric services. Our concerns are summarized as follows:

- o BMAD data may not adequately reflect low charge histories that flow from statutory limits on Medicare payment for psychiatric services.

  Medicare reimbursement for psychiatric medical services is unique. Because of the complex regulatory and legislative history of Medicare reimbursement for psychiatry (such as, for example, the $250 federal share cap on Medicare payment for outpatient psychiatric services rate, which was raised incrementally and ultimately eliminated) APA believes that low historical charge data for psychiatric services has had an impact on the BMAD allowable charge data set used by HCFA for the MFS.

- o BMAD data or its use may not account for the effective fifty percent beneficiary copayment for outpatient psychiatric services.

  The effective fifty percent co-payment imposed upon outpatient psychiatric services -- through the antiquated 62.5% of 80% statutory limit on allowable charges -- adds a greater complexity to calculating Medicare allowable charge figures and reimbursement amounts for psychiatric services. APA believes that these factors have led to errors in calculating and the use of the BMAD data files, but HCFA has not yet analyzed or validated its BMAD data.

- o BMAD data or its use may not account for low charges that flow from site of service.

  APA is very concerned that HCFA has used BMAD average allowable charges that may have integrated inpatient and outpatient hospital and office charge data. Psychiatric services provided to non-elderly disabled Medicare beneficiaries are very often provided in hospital outpatient departments or community mental health centers. Charges for services provided in these locations are historically low, not because the service provided is low-cost, but because payment is subsidized from other sources. If these charges have not been disaggregated from office outpatient or hospital inpatient payments, they will have the effect of "low balling" payment calculations based on BMAD averages.

- o Use of BMAD average allowed charges may be particularly inappropriate for psychiatric services under Medicare.

  To the extent that specialties such as psychiatry have "clustered" their payments around the Medicare prevailing charge in a charge locality, use of a BMAD average allowed charge will substantially understate the appropriate payment for services. APA believes that some other more appropriate statistical measure, rather than the average "allowable charge" should be used to produce the 1992 Medicare Part B outlay projections.

  The average allowable charge roughly represents the fiftieth percentile of allowable charges, in any given geographic area, and thus understates actual charge experience. Using both the allowable charge data plus geographic adjustment factors acts as a "double hit" upon all physicians, including psychiatrists, who have had historical charge patterns above the fiftieth percentile, especially those located in geographic areas where the prevailing charges are above the national norm for any given physician service, thus producing substantial reductions in reimbursement.

- Flawed BMAD data may have significantly skewed psychiatric RVUs for malpractice and office overhead.

  As noted, we believe that the BMAD data failed to account for the fact that Medicare pays "50 cents on the dollar" for outpatient psychiatric services, as opposed to the normal "80 cents on the dollar." If malpractice and office overhead were calculated as a percentage of average allowed charges, as we believe they were, the miscalculated BMAD data for outpatient services would have the effect of substantially reducing psychiatric malpractice and overhead components. This in turn will reduce total reimbursement for psychiatric services under the new Fee Schedule.

6. Integration of the Phase III Hsiao Research:

HCFA has acknowledged informally that some preliminary Phase III work from the Hsiao Harvard team was integrated into the proposed Medicare Fee Schedule. The Phase III work will finalize the Evaluation and Management codes (i.e., the new five-level office visit coding system and the multi-level hospital visit coding system) and is of special importance to psychiatry because all of psychiatry's cross-specialty links are office visits. Not knowing what Phase III work is included in the NPRM and how the final Phase III work will affect the Fee Schedule's outcome for psychiatric services makes it exceedingly difficult to evaluate the proposed Fee Schedule. We believe that it is inappropriate for preliminary Phase III work to be included in the proposed MFS at this time, and certainly without a detailed analysis of the impact of its inclusion.

Clearly the proposed Fee Schedule is a "moving target" that will be modified by the forthcoming Phase III Harvard research. To say the least, APA is extremely frustrated by the "moving target" nature of the Fee Schedule. All the data are not yet in, and APA along with the every other medical specialty will not have an opportunity to analyze and comment on the entire set of Harvard research used to calculate the new RBRVS Medicare Fee Schedule before the final Rule Making.

APA fully understands and appreciates that the development of the new RBRVS Medicare Fee Schedule is a monumental and complex task but believes it arbitrary and capricious to move to a final rule without an additional comment period after the release of necessary data and analyses upon which to respond substantively for consideration. Once complete the RBRVS system will not only radically alter Medicare Part B physician payment, but also portends "adoption" by other third party payors. The broad and long-term impact of the new Medicare Fee Schedule for physician payment requires that its development be void of significant errors -- such as those outlined above -- as well as that it be based upon the principles of sound methodology and fairness.

Mr. Chairman, APA supported physician payment reform on a budget neutral basis, not reform sacrificed on the altar of cost cutting disguised as neutrality. The imposition by HCFA of a drastic one-year behavioral offset is nothing more than a three billion dollar budget-cutting device and extremely unfair because HCFA presumes physicians will be guilty -- to gross proportions -- in ratcheting up utilization. The "guilty until proven innocent" approach to anticipatory increased volume of medical service beyond the so-called Medicare Volume Performance Standard (MVPS) is unwarranted and should be rejected. Moreover, whatever your response to the conversion factor and so-called "behavioral offset", we would urge your consideration of the fact that since most psychiatric services are time-constant, psychiatry cannot respond to Fee Schedule payment reductions by increasing time or intensity of service.

In sum, the impact of the proposed MFS is a devastating blow to the provision of mental health services to America's elderly. The MFS impacts not just on psychiatry, but also on allied mental health services such as psychology and social work, whose reimbursement is a percentage of reimbursement for services provided by psychiatrists.

We find that the proposed MFS and the methodology used to develop it is so fraught with possible errors that we can reach only one conclusion: Congress should require HCFA to withdraw the proposed MFS until HCFA has released all data and methodology used in the development of the MFS and has either validated the MFS or corrected its errors. Once that has occurred, the medical community can respond with comments on hard fact, not on the "Will O' the Wisp" that this fee schedule now represents.

ASCRS
AMERICAN SOCIETY OF
CATARACT & REFRACTIVE SURGERY

STATEMENT OF THE AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY BEFORE THE HOUSE WAYS AND MEANS COMMITTEE, SUBCOMMITTEE ON HEALTH ON MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE-BASED RELATIVE VALUE SCALE

Introduction and Summary

The American Society of Cataract and Refractive Surgery ("ASCRS") is pleased to have this opportunity to comment on Medicare payments for physicians' services under the resource-based relative value scale ("RBRVS"). ASCRS appreciates the concern expressed by Chairman Stark that the proposed implementation of the RBRVS-based physician payment reform methodology by the Health Care Financing Administration ("HCFA") may depart from the intent of the authorizing reform statute in significant respects. ASCRS also notes Chairman Stark's expression of interest in assembling representatives from HCFA, physician groups and Congressional staff to address these problems.

ASCRS expresses a strong interest in joining this essential dialogue, particularly because of a profound concern about flaws in the underlying basis of the proposed physicians' fee schedule. An original premise of the entire physician payment reform system was that it should reflect the expertise and consensus of the medical community, especially concerning the relative valuation of medical procedures that is at the heart of the system. For ophthalmology at least, this original premise has not been fulfilled because the valuation of ophthalmic procedures in HCFA's proposal and the Hsaio study on which it is partially based ignored the views of the panel of ophthalmic experts that was convened to advise on relative values for this specialty. This fact represents a failure in the process upon which the fee schedule is based and produces inaccurate and inequitable results that will be discussed in greater detail later in this statement.

At this point, ASCRS is at an early stage in its analysis of the numerous issues in HCFA's notice of proposed rulemaking ("NPRM") that affect cataract surgeons. Consequently, the bulk of our statement will be devoted to two general issues, the conversion factor calculation and the scaling of relative values. The remainder of the statement will briefly highlight some other issues of specific concern to ophthalmology. ASCRS respectively requests the opportunity to supplement its statement with more detailed comments on these specific issues at a later time.

General Issues: The Conversion Factor Calculation and Relative Value Scaling

Conversion factor calculation

The calculation of the initial conversion factor ("CF") is in many ways the linchpin of the physician payment reform system because, more than any other aspect of that system, the CF affects the payments that all physicians will receive from Medicare in 1992 and all future years. ASCRS submits that the CF calculation is seriously flawed and must be carefully re-examined because it rests on several assumptions that are: 1) not supported in the statutory mandate for the physician payment reform system; 2) not supported empirically; and 3) likely to have serious, dislocating and unintended consequences, certainly for the specialty of cataract surgery and its patients. Each of these concerns about the assumptions underlying the CF calculation is explored below.

In many respects, the following discussion echoes concerns raised by the Physician Payment Review Commission ("PPRC") in its statement before this Committee. The PPRC was established by Congress to provide expert study and analysis as a basis for policy decisions involved in the physician payment reform system, and therefore the views of the Commission should be considered carefully by both HCFA and Congress in addressing the NPRM.[1/]

The PPRC has identified several assumptions that are integrally involved in the calculation of the initial CF and has criticized these assumptions strongly. These assumptions are: 1) that physicians will respond to changes in Medicare payments caused by the fee schedule by increasing the volume of their services and changing billing practices to bill more frequently for higher-code items, so that a full 50% of fee reductions will be offset (the so-called "behavioral offset"); 2) specific volumes of evaluation and management services (set forth at 56 Fed. Reg. 25821) will be billed under each of HCFA's newly revised visit and consultation codes; and 3) all bills will be for the fee schedule amount or more, and no claims will be submitted for amounts less than the fee schedule levels. Each of these assumptions results in deflating the initial CF. Since the CF has a leveraging effect on payments to physicians, the consequences of these errors are extremely far-reaching.

ASCRS' first objection to these assumptions is that they are without basis in the statutory mandate for the physician payment reform system in §6102 of the Omnibus Budget Reconciliation Act of 1989 ("OBRA'89"). Nowhere in the statute is there any mandate for a behavioral offset, any particular direction about how to project the number of evaluation and management services under new visit codes, or any mandate about assumptions on the number of claims that would be billed at or above fee schedule levels. Rather, Congress' only mandate concerning the conversion factor calculation was that it be "budget neutral." Congress did not direct that the CF itself be used as a means for controlling budgetary outlays; rather, that objective was to be achieved through the Volume Performance Standards ("VPS").

By making the most conservative possible assumptions concerning the CF calculation, however, HCFA's NPRM makes the CF itself a mechanism for achieving payment reduction. In many cases, particularly those of cataract surgeons, these reductions will be sudden and drastic; however, Congress did not direct this result. The overall purpose of the physician payment reform method was to establish a more rational system of physician payment under Medicare, not to slash payment radically. Indeed, Congress signified exactly the opposite intention by providing that payment for services above or below the fee schedule would be "transitioned" into the fee schedule over a four-year period, and even more significantly, that reductions in updates through the VPS system would be strictly limited. Thus, the assumptions that HCFA has used to calculate the lowest possible initial CF are without statutory basis.

ASCRS' second objection to those assumptions is that none of them is empirically justified, as the PPRC aptly stated in its testimony before this Committee. As to the behavioral offset, ASCRS is aware of no empirical study justifying the substantial 50% behavioral offset that HCFA has posited. As the PPRC has

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1/ ASCRS wishes to note, however, that it does not agree with the PPRC on every single issue involved in the development of the fee schedule. For example, the PPRC has largely ignored the role that patient outcomes can and should play in the assignment of relative values, even though data on outcomes is now available. ASCRS believes that a true "relative value" system must incorporate the concept of value to the patient, a point that we will explore at greater length in later comments on the NPRM.

noted, the entire issue of behavioral response is one where "great uncertainty" about predictions exists, and HCFA "has made a worst-case assumption." (Statement of the Physician Payment Review Commission on HHS's Notice of Proposed Rulemaking Before the Subcommittee on Health, Committee on Ways and Means (June 25, 1991) (hereinafter, "PPRC Statement") at 4.

Indeed, there is some relevant empirical evidence that suggests that any assumption about a "behavioral offset" is completely unjustified. First, Medicare actuaries' data show that physician services' volume growth has been slightly lower from 1984 to the present -- a period during which physician fees in numerous specialties, including cataract surgery, were steadily reduced through a general 1984-1986 fee freeze and then a series of cuts for "overpriced" procedures -- than for the period before 1984, when fee cuts were not so frequent. Similarly, experience with the behavioral responses of hospitals to the Prospective Payment System ("PPS"), which is similar in intent and effect to the physician payment reform system, shows that hospitals did not in fact attempt to offset the fee constraints imposed by the PPS by increasing the volume and intensity of services. Notably, when confronted with the same "budget neutral" mandate for the PPS as it confronts today, HCFA did not choose to assume a behavioral offset before the fact, but instead chose to cope with the prospect of such responses through admission pattern monitoring.

Third, it must be noted that all physician specialties are not able to respond to fee cuts by increasing the volume and intensity of services because they do not order their own services. Such specialties, for example, include radiology, anesthesiology, pathology and others. Since these specialties can achieve, in effect, only a 0% "behavioral offset," HCFA's general 50% behavioral offset assumption implies a greater than 50% behavioral offset assumption for other specialties -- a radical assumption that, again, is without support in any empirical studies of which we are aware.

For cataract surgeons, the 50% assumption itself is also wrong because it is inconsistent with trends in the demand for Medicare-covered cataract surgeries and recent evaluations of the utilization of such procedures. Specifically, the Department of Health and Human Services Office of Inspector General ("OIG") recently concluded that only 1.7% of cataract surgeries were unnecessary. This experience has occurred following a period of time when cuts in cataract surgery and intraocular lens ("IOL") payments occurred almost annually for several years -- i.e., a period when cataract surgeons could certainly have been expected to employ a "behavioral offset" by providing more unnecessary surgeries. The 1.7% OIG figure shows that any such "behavioral offset" was minimal. Additionally, it is critical to note that the average age of cataract patients has dropped from over 65 to under 65, so that the population of Medicare cataract patients from whom a behavioral offset could be drawn is shrinking, not growing. Peak volume for cataract surgeries occurred in 1988 and has fallen since.

With respect to the the numbers of evaluation and management services that will be billed under newly revised visit and consultation codes, again, HCFA has made an extreme assumption in an area where important empirical data is lacking. As the PPRC has noted in its statement, "regrettably, HCFA had little data to guide it." Id. Indeed, HCFA itself admits in the NPRM that all of its data sources for this projection are very inadequate. See 56 Fed. Reg. 25821. The Commission simulated alternative assumptions that were actually based on data from logdiary surveys of physicians. The Commission's simulation resulted in 13% lower projected outlays for visits, and consequently a CF 5% higher than HCFA's prediction.

The PPRC has also pointed out that data concerning actual physician billing patterns is relatively easy to accumulate

because physician billing patterns for visits have been relatively stable over time. The Commission suggests that Congress could direct HCFA to revise the CF in the future if visit patterns vary significantly from the projection. While the Commission does not state that this option suggests HCFA should make the most moderate assumption about visit code billing, ASCRS does so suggest. Once embedded in the CF calculation, an unwarranted visit code assumption will have immediate and substantial effect on physician payments and, consequently, patterns of service, that will not be able to be reversed even if the assumption is later revised on the basis of experience.

Finally, HCFA's assumption that all bills will be for the fee schedule amount or more is similarly without empirical basis. Indeed, this assumption is contrary to current experience, which shows that, in the PPRC's terms, "a significant minority of claims" are billed for amounts below current prevailing charge levels. The PPRC has labeled HCFA's assumption in this area "unrealistic," and ASCRS agrees. While the PPRC suggests that Congress could direct HCFA to revise the CF in the future on the basis of actual experience, ASCRS urges that, to avoid unintended dislocating effects of a too-low CF, HCFA be directed to make an assumption concerning billing levels that is consistent with existing experience under the customary, prevailing and reasonable ("CPR") physician payment system.

ASCRS' third objection to HCFA's conversion factor calculation is that it results in draconian payment cuts for cataract surgeries that will adversely beneficiary access. The projected impact of the physician payment reform system as proposed in the NPRM is that payments per service for ophthalmology and for anesthesiology, upon which cataract surgery relies, will each decline by 35% by the end of the transition period in 1996 -- the two largest specialty cuts under the entire fee schedule. Much of this decrease will be accomplished even faster. For two specific cataract surgery codes (66821 and 66984), the payment picture is even grimmer. For code 66821, average payments will fall 44% by the end of the transition; for code 66984, the cumulative drop will be 38%. These total drops in cataract surgery payments under the physician payment reform proposal come on the heels of series of substantial physician payment and cataract surgery-specific payment cuts throughout the second half of the 1980s. Thus, during the decade 1986 through 1996, the cumulative decline in Medicare payments for cataract surgery will be a whopping 58%. Fee schedule levels for cataract surgery will be lower than Medicaid's; payments for IOLs will be below levels that prevailed over 15 years ago in 1974.

These enormous payment cuts are very likely to affect beneficiary access to care. Contrary to HCFA's assumptions, the most logical response of cataract surgeons to these drastic cuts will be to shift their practice patterns away from Medicare business rather than pursuing a "behavioral offset" by increasing nonremunerative Medicare work. For example, some cataract surgeons will shift their practices to refractive surgery, which is more heavily weighted toward non-Medicare work, or to dispensing. Others will simply choose to take early retirements rather than continue under the pressures of demanding and now unrewarding cataract practices.

These kinds of responses will be especially severe in rural areas, where cataract surgery is performed infrequently. In such localities, individual physicians perform only a handful of such surgeries per month, and will most likely choose not to bother continuing to offer this service. Thus, rural patients in need of cataract surgery will suffer a loss of access -- a result contrary to the intention Congress has expressed in Medicare laws throughout the 1980s to preserve the availability of medical services to patients in rural areas. Certainly, curtailing beneficiaries' access to needed Medicare-covered services that improve their physical and mental wellbeing was not one of the objectives of the physician payment reform statute.

Relative value unit scaling

After the conversion factor, the other component of the physician payment reform system that most determines payment levels is the Relative Value Unit ("RVU") scale. As with the calculation of the CF, HCFA's NPRM reflects some errors and omissions that have been identified by the PPRC and require correction before the fee schedule system can be implemented. Among those errors that the PPRC has identified in the RVUs are the following.

First, the NPRM includes no policy for categorizing invasive services (including cataract surgery) as global or nonglobal. The difference between global and nonglobal services is extremely important because a surgical global payment covers the entire range of services provided within several months of the surgical procedure that are related to the condition requiring surgery, while a nonglobal payment only covers those services that are directly related to the performance of the surgical procedure itself. Without a policy in this area, payment inequities and billing confusion will result because services that are usually provided for patients with disparate conditions may be categorized as global surgeries rather than nonglobal procedures. Consequently, there can be substantial variations in the actual work covered by the global fee between procedures on different patients, yet the payment will be the same.

An additional reason why the NPRM's treatment of invasive services is flawed and needs further work is that, as the PPRC has noted, HCFA did not establish its global and nonglobal surgery definitions in time for the Hsaio team to incorporate those definitions into the determination of physician work RVUs for invasive services. Consequently, the PPRC points out, "all nonglobal procedures...are substantially undervalued in the NPRM. The relative work values for these services reflect only the work involved in performing the procedure itself, whereas the payment is intended to cover all services directly related to the procedure that are performed within 30 days." Obviously, this error creates a serious payment inequity that was not intended by Congress and must be corrected.

Another area of RVU scaling where the PPRC has identified errors in the NPRM is that the RVUs for evaluation and management services do not reflect differences in the work effort required to provide different types of visits, such as a visit or consultation for a brand new patient versus a routine visit with an established patient. Again, this omission in HCFA's RVUs will result in unintended payment inequities.

The PPRC has also noted that the RVUs proposed by HCFA may in some cases require changes to align the Hsaio study scale for work to the Medicare population and to correct inaccuracies in the underlying vignettes upon the Hsaio study was based. As the Commission points out (PPRC Statement at 7), "these problems are not uncommon, affecting as many as 10% of the services provided by some specialties."

Still another potential problem area in the RVUs that ASCRS has identified relates to the ranking of ophthalmic RVUs. Specifically, studying the ophthalmic RVUs in the model fee schedule published by HCFA September 4, 1990 versus those in June 5, 1991 NPRM, ASCRS noted that the ranking of values of the ophthalmic codes has changed substantially without explanation by HCFA. This change suggests additional potential errors in the RVU scaling or, at a minimum, an area requiring further examination before the physicians' fee schedule can be implemented.

In summary, the numerous and significant areas in which HCFA's RVU scale is flawed means that the new system cannot be implemented as currently proposed by HCFA and truly achieve the original intent of Congress to create a more rational and equitable system of Medicare payment for physicians.

Specific Issues

The following is a brief and partial list of those specific issues in the NPRM that ASCRS has identified as problem areas for ophthalmic procedures. We are now in the process of completing this list of issues and beginning to work on recommendations for solutions which we hope to be able to bring to the Committee's attention in the near future.

Undervaluing of ophthalmic survey RVUs

ASCRS wishes to point out that HCFA's RVUs for ophthalmic surgery may reflect significant undervaluing of retinal and vitreous surgery. Contrary to an assertion in the NPRM that Phase III of the Harvard study used "small groups of physicians to detect and correct erroneous values," (56 Fed. Reg. 25795), concerns expressed by the ophthalmic Technical Review Panel with regard to undervaluing of these surgeries were simply ignored by the Hsaio study team. This situation results in inaccuracies and inequities in the RVUs scale and fails to reflect the consensus evaluation that was one of Congress' key objectives concerning the development of the RVU scale.

Inappropriate global survey definition

HCFA's global surgery definition is an extremely broad package that includes all preoperative hospital and office visits for 30 days preceding surgery, all intraoperative work, all postoperative visits for 90 days following surgery, and most postoperative complication treatments. This definition is inappropriate for ophthalmic surgeries because it does not take into account important specific conditions in ophthalmic surgery. Ophthalmic surgery patients may suffer conditions requiring intensive preoperative and postoperative care that would not be adequately compensated under the global surgery fee.

For example, in the preoperative area, if the patient had conjunctivitis, the surgeon would have to perform diagnostic tests and numerous re-examinations of the patient before making a final decision to proceed with surgery. If the patient developed a miotic pupil due to chronic use of polocarpine drops, discontinuation of the drops, substitution of other agents and extensive monitoring before surgery would be required. With regard to postoperative complications, a patient may develop hyphemia requiring several days of hospital care by the physician. A patient may develop endophthalmitis requiring intensive antibiotics and careful co-management by the primary surgeon and the vitreous surgeon. Similar co-management would be required in the case of dislocated nucleus in the vitreous.

As these examples suggest, HCFA's global surgery definition is not sufficiently refined to deal with the conditions existing in ophthalmic surgery.

Inequitable multiple surgery policy

In a case where a patient has multiple surgeries on the same date, HCFA proposes to establish surgery fees by paying 100% of the global surgery fee for the most expensive surgery, 50% of the global fee for the second most expensive surgery and 20% of the global fee for the third most expensive surgery, etc. The proposal may produce some inequities and results that are contrary to the best interests of the patient. For example, a patient may sustain trauma to orbit with a blowout fracture of orbit and a corneal laceration, both of which must be repaired. The blowout fracture repair is the most expensive procedure, and would probably best be performed by an oculo-plastic surgeon. However, if the general ophthalmologist would only receive 50% of the global surgery fee for repairing the corneal laceration, he might well be tempted to perform the repair of the blowout

fracture himself, even though the best care for the patient required repair by the oculo-plastic surgeon.

Incentives for provision of surgical services by nonphysicians

HCFA's proposed policy for addressing situations where portions of the global surgery package are provided by different practitioners (56 Fed. Reg. 25842) raises concerns about the prospect of preoperative and postoperative care being furnished by nonphysicians. HCFA's proposal is that the sum of the amounts paid to individual practitioners will not exceed the global surgery fee. This proposal creates incentives for surgeons to delegate some preoperative and postoperative care to nonphysician practitioners with lower fee levels, a result that may in many cases deprive the patient of adequate care -- particularly where very sensitive decisions concerning surgical risks are involved or complications occur.

Inadvisable elimination of time for anesthesia services

HCFA's proposal to eliminate time as a separate payment element for physician anesthesia services will have a particular effect on ophthalmic surgery which is seriously adverse to patient interests. Elimination of time as a payment element for anesthesia will create an incentive for anesthesiologists to perform simpler, faster anesthesiology procedures that may not be nearly as effective. Additionally, in ophthalmic surgery, constant intraoperative and postoperative monitoring by the anesthesiologist are essential because patients are elderly and often have systemic illnesses such as diabetes and cardiac arrhythmias that may be affected by anesthesiologist. The elimination of time as a criterion for anesthesia payments will create incentives to curtail this essential monitoring by the anesthesiologist. The elimination of the time criterion will also place pressure on ophthalmic surgeons themselves to perform procedures quickly because intraoperative monitoring by the anesthesiologist is essential throughout. Consequently, HCFA's policy may produce less than the best performance from those ophthalmic surgeons who are extremely effective in their surgical results but work thoroughly and slowly.

Inequitable treatment of new physicians

The NPRM proposes to address payments for new physicians by limiting payment in the first year of practice to 80% of the fee schedule amount, payment in the second year to 85% of the fee schedule amount, payment in the third year to 90% of the fee schedule amount, and payment in the fourth year to 95% of the fee schedule amount. While we recognize that this policy predates the physician payment reform system, the substantial cuts that this system will produce demand a re-evaluation of the new physician policy to avoid discouraging physicians from entering into the practice of ophthalmology altogether. In ophthalmology, unlike many other specialties, startup of practice requires a very substantial investment in equipment. Thus, the beginning practitioner bears a much greater financial burden than his more senior colleagues that the new physician policy does not recognize. Moreover, there is no evidence in the area of ophthalmology that beginning ophthalmic surgeons are less skillful than others. Thus, the new physician policy constitutes an unwarranted and discouraging penalty.

The summaries above represent only a few of the aspects of the NPRM that may be ill-designed for ophthalmology and possibly other specialties. Again, ASCRS wishes to emphasize that this list is apparently only partial and that we are still in the process of developing recommendations for changes. However, the above list amply points out the serious need for closer examination and more careful design of numerous policies reflected in the NPRM. The need for careful consideration of these policies is heightened by the potentially devastating effects of the CF calculation.

Conclusion

For the foregoing reasons, ASCRS strongly urges Congress to assure that the physician payment reform system is not implemented by HCFA without adequate consideration and without the physician input necessary to avoid unintended and inappropriate results. ASCRS expresses its hope to play an active role in this process, given the extensive effects of this system and the NPRM policies on ophthalmic surgery.

STATEMENT OF THE
ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

The Association of Freestanding Radiation Oncology Centers ("AFROC") is an association of over 150 freestanding oncology centers located throughout the country. Freestanding radiation oncology centers are health care facilities organized and operated to provide high-quality, cost-efficient radiation oncology services to patients in their communities outside of the hospital setting. It is estimated that there are approximately 300-350 freestanding radiation oncology centers located throughout the country. Freestanding radiation oncology centers are heavily dependent on Medicare reimbursement, since approximately 55% of patients treated by such centers are covered under the Medicare program.

The provision of radiation oncology services outside the hospital setting requires significant capital investment, and the ongoing operation of such centers entails high expenditures for specialized staff, equipment, equipment maintenance, and other "facility" costs. In effect, such costs are comparable to the "facility" costs incurred by hospital outpatient departments that provide the same services.

Such "facility" costs are not reimbursed separately by the Medicare program; rather these "facility" costs are currently reimbursed as the "technical" component of radiation oncologists' fees, under the radiology fee schedule. Unfortunately, the radiology fee schedule does not take into account extraordinary facility costs involved in providing radiation oncology services in freestanding settings. The relative values for radiation oncology "technical" services were derived by the American College of Radiology using a methodology that did not take these cost into account. For this reason, the reimbursement allowed under the radiology fee schedule does not cover the actual costs of providing radiation oncology technical services, and the cost of providing these services must be cross-subsidized using revenues obtained from other third party payers.

Moreover, after the implementation of the radiation fee schedule in April 1989, Congress enacted legislation which reduced reimbursement for radiology services (including the technical component of radiation oncology services) by approximately 30% in 1989, 4% in 1990, and approximately 9.5% in 1991.

As a result of these factors, a study conducted by AFROC during the period from December 1990 through January 1991 established that reimbursement would have to be increased by atleast 47% to ensure that technical relative values are sufficient to cover actual costs. More specifically, from December 1990 through January 1991, the Association of Freestanding Radiation Oncology Centers ("AFROC") sponsored a survey of the technical costs incurred by freestanding radiation oncology centers. No member of the Board of Directors nor any other member of AFROC was provided access to any of the individual data collected.

Approximately 80 facilities responded to the AFROC survey, representing approximately 23-27% of all freestanding facilities in the country. The survey respondents were divided into categories, depending upon the number and type of treatment units available at the facility, and, for each of these categories of facilities, annual technical costs were computed. The average number of treatments provided by each type of facility was also computed by annualizing survey data for the three-month period from July to September 1990.

After obtaining the average number of patients for each type of facility and the average cost for each type of facility, a "break-even conversion factor" was computed by dividing the total costs by the total current relative values. This conversion factor represents the conversion factor that would be necessary in order for each type of facility to "break-even" given current relative values. The results are as follows:

	SINGLE UNIT CENTER BEAM ENERGY (MV)				TWO UNIT CENTERS
	0-5	6-10	11-19	20+	
# of centers	20	39	2	1	17
Tech cost($K/yr)	497	800	916	1,027	1,490
Treatments/yr	3,332	5,584	5,788	5,548	12,780
Tech RVUs/yr	27,257	46,241	47,872	45,898	105,733
Tech cost ($)/RVU	18.09	17.31	19.13	22.39	14.09

Thus, the study demonstrated that, regardless of the category of the facility, current reimbursement levels are too low to cover actual costs. In fact, using this data, AFROC has calculated that an increase of approximately 47% in the current relative values for these services would be necessary in order for freestanding radiation oncology centers to "break-even." These results were confirmed by an independent study conducted by Pro-Med, a cancer center management and consulting firm.

The Health Care Financing Administration ("HCFA") is now in the process of integrating the current radiology fee schedule, however, (including the current reimbursement for freestanding radiation oncology centers) into the resource-based relative value scale ("RVRVS"). In its recently proposed Notice of Proposed Rulemaking ("NPR"), HCFA proposed a further 10-15% reduction in reimbursement for radiation oncology technical services. This proposal is entirely inconsistent with a "resource-based" approach to reimbursement, since the current reimbursement levels were not based upon study of the resources involved in the provision of radiation oncology services in freestanding settings. In addition, this proposal is inconsistent with the approach recommended by the Physician Payment Review Commission ("PPRC"), which has recommended that reimbursement be based on a study of the actual resources used.

For these reasons, AFROC respectfully requests that the Committee urge HCFA to adopt reimbursement levels for radiation oncology services that accurately reflect the resources used and support the introduction of legislation that would require HCFA to take into account the resources used in the provision of these services in implementing RBRVS, if HCFA fails to take these extraordinary costs into account in finalizing the fee schedule.

If you have any questions or need any further information regarding AFROC's position on this issue, please contact AFROC's legal counsel, Diane Millman at (202) 778-8021.

8622h

STATEMENT OF THE

COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to discuss problems with the Administration's calculation of Medicare physician fee schedule amounts for 1992 through 1996. The College represents more than 12,000 board-certified pathologists who provide diagnostic and consultative services to Medicare patients in hospitals, nursing homes, clinics and offices, and other settings in which health care services are provided.

The College is extremely concerned that the methods used by the Secretary of Health and Human Services (HHS) in calculation of the Medicare relative value scale (RVS) conversion factor (CF) for 1992 are erroneous and produce fee schedule amounts that are ridiculously low. We ask that the Omnibus Budget Reconciliation Act (OBRA) of 1989, which created the RVS payment system, be amended to prohibit the Secretary from using these methods. This change will allow the RVS CF to increase, while maintaining the budget neutrality envisioned by the Congress.

Problems in Conversion Factor Calculation

The Secretary of HHS has used several techniques in calculation of the RVS CF that reduce the CF by 16 percent for 1992 and that will have the long-term effect of reducing fee schedule amounts in 1996 when the RVS is fully phased-in. These are:

1. The Secretary assumes that physicians will respond to RVS changes by increasing the volume and intensity of services provided so that 50 percent of any expected losses would be recouped. The CF is decreased by 10.5 percent to enable the government to recapture these monies.

   There is no evidence to support the Secretary's assumption. In fact, available research leads to the conclusion that no one can predict what effect this totally new relative value system will have on volume and intensity of services. Since pathologists do not control the volume of surgeries, consultations, or other events that produce the need for pathology services, there is no way for our specialty to respond to the RVS by increasing services provided. Yet the CF reduction would apply to our services.

   The Medicare Volume Performance Standard (MVPS) limit on the increase in Medicare payments was designed to adjust physician payments if volume increases do occur. That mechanism is in place. The behavioral assumptions made by the Secretary preempt that mechanism and are redundant.

2. The Secretary has reduced the CF by an additional six percent to adjust for effects of the RVS phase-in methodology. The five-year phase-in was explicitly designed to allow increases in Medicare payments for certain services to proceed more quickly than would decreases for services scheduled to be reduced. This mechanism protects against large decreases in early phase-in years and allows time for RVS refinement and correction as necessary.

   Because of this phase-in asymmetry, the Secretary has reduced the CF to maintain budget neutrality. The effect is to take money out of the Medicare payment system that would be spent under true budget neutrality and to reduce Medicare fee schedule amounts even further.

   We ask that the Secretary be prohibited by statute from using these techniques to reduce the conversion factor.

Additional Relative Value Scale Concerns

The College has additional concerns with other aspects of the plans for RVS implementation. These include:

A. The legislation creating the Medicare RVS fee schedule includes a provision for lower fee schedule amounts for new physicians in their first four years of

practice. There is no sound basis for this provision under a resource-based payment methodology such as the RVS fee schedule. The very basis of the fee schedule is that all physicians would be reimbursed on the basis of average resources involved. New physicians should be treated likewise as there is no reason to think they expend less resources.

We ask that this OBRA 1989 provision that treats new physicians inequitably be repealed.

B. The Medicare resource-based relative values for pathology and most other services are based primarily on the work of Harvard University researchers. The Secretary has the discretion to use the data in various ways to calculate relative values and has the authority to develop other payment policies for RVS implementation. We have several concerns with how the Harvard data have been used to calculate relative values, with the manner in which agreed-to crosslinkages have been manipulated, and with the assumptions used to develop the technical component relative values for pathology services. Adjustments are necessary for proper use of the Harvard data and to ensure adequate relative values for the technical components. We will be pursuing those refinements with HHS.

We strongly encourage the Committee not to assume that the work necessary to support RVS implementation is completed and that relative values are final. Substantial refinement is needed in the proposed relative values.

Summary

The College has serious concerns with plans for implementation of the Medicare RVS in 1992. The Secretary of HHS should be prohibited from presuming physician behavioral changes and from reducing the fee schedule conversion factor to adjust for asymmetry of the phase-in period. There is no basis for the behavioral assumptions, and the phase-in asymmetry was planned to protect against access problems in early years of the RVS.

In addition, we urge repeal of the OBRA 1989 provision establishing lower fee schedule amounts for physicians in their first four years of practice. There is no basis for this differential.

We encourage the Committee to be aware that RVS refinements are needed.

Thank you for the opportunity to present the College's concerns with plans for Medicare RVS implementation.

College of Physicians & Surgeons of Columbia University

Office of the
Vice President for Health Sciences
and Dean of the Faculty of Medicine

630 West 168th Street
New York New York 10032
(212) 305-3592 Fax (212) 305-3545

July 1, 1991

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Dear Congressman Stark,

I am writing to submit a written statement for the printed record of the hearing conducted on Tuesday June 25, 1991 regarding Medicare payment to physicians under the resource-based relative value scale.

We believe that there are many problems with the proposed fee schedule published by HCFA in the June 5, 1991 Federal Register and that in particular, the conversion factor must be corrected. The proposed system is departs significantly from the original legislative intent.

Manhattan physicians would suffer a devastating and disproportionate reduction in reimbursement under the proposed system, in part because the methodology used does not accurately reflect the costs of practicing medicine in Manhattan. As the attachments show we have been actively concerned about this issue for the past eight months and have communicated with our legislative representatives, HCFA and the Physician Payment Review Commission.

With the publication of the June 5, 1991 Federal Register, it became clear that the impact of the new system would be even worse for Manhattan physicians than originally predicted. It appears that payments to our physicians for management and evaluation services will decline by over 30%, and for most other services by much larger percentages once the system is fully implemented. The response we have received from HCFA suggests that it is unwilling to consider adjustments in geographical cost factors before 1993 at the earliest.

We strongly urge that legislation be considered that would return physician payment reform to the budget neutral basis that Congress intended originally, and that would require HCFA to devise a system that does not result in undue harm to any geographic locality for the sake of national uniformity.

Sincerely,

HERBERT PARDES, M.D.
Vice President for Health Sciences
and Dean of the Faculty of Medicine

College of Physicians & Surgeons of Columbia University

Office of the
Vice President for Health Sciences
and Dean of the Faculty of Medicine

630 West 168th Street
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March 1, 1991

For your information the attached packet has been sent to the following:

Philip Lee, M.D.
Chairman
Physician Payment Review Commission

Lauren LeRoy
Deputy Executive Director
Physician Payment Review Commission

John Eisenberg, M.D.
Commission Member
Physician Payment Review Commission

Gail Wilensky
Administrator, Health Care Financing Administration
Department of Health and Human Services

Kathleen Buto
Director, Bureau of Eligibility, Reimbursement and Coverage
Health Care Financing Administration

Senator Alfonse M. D'Amato
Senator Daniel Patrick Moynihan
Congressman Bill Green
Congressman Charles Rangel
Congressman Theodore S. Weiss

Kathleen O'Donnell
Associate Dean and
Deputy Vice President for
Medical Center Affairs

College of Physicians & Surgeons of Columbia University

OFFICE OF THE
VICE PRESIDENT FOR HEALTH SCIENCES
AND DEAN OF THE FACULTY OF MEDICINE

630 WEST 168TH STREET
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February 27, 1991

Gail Wilensky, Ph.D.
Administrator, Health Care Financing Administration
Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Dear Dr. Wilensky:

I am writing on behalf of the faculty physicians of the College of Physicians and Surgeons of Columbia University to emphasize our serious concern about the devastating financial impact the proposed changes in Medicare physician payment policy, specifically the proposed 1992 Medicare resource based fee schedule, will have on the practice of medicine in Manhattan. In November 1990 we wrote to the Health Care Financing Administration (HCFA) to comment on the September 4, 1990 Federal Register preliminary Medicare Model Fee Schedule (copy attached). While we stated our support for efforts to establish a more logical and equitable system of Medicare reimbursement for physician services, we emphasized our serious concern about many elements of the proposed schedule. Based upon additional information we have obtained since then, we continue to be concerned.

Our faculty physicians provide patient care services at the Presbyterian Hospital in the City of New York, at the Harlem Hospital Center, and at the St. Luke's-Roosevelt Hospital Center in Manhattan, New York. Together, over 2,000 physicians at these three major teaching affiliated hospitals of the College of Physicians and Surgeons provide the bulk of patient care services to residents of the west side of Manhattan, roughly 30 to 40% of whom are Medicare patients. The three hospitals have over 3,500 beds, and in 1990 had over 115,000 discharges and over 2 million outpatient and emergency room visits. The combined level of indigent and subsidized or free care provided by our faculty physicians and affiliated hospitals in Manhattan is probably unequalled anywhere in the country.

Based upon our initial preliminary analysis, including review of survey data collected in December 1990 by the American Association of Medical Colleges, AAMC, (AAMC Medicare Model Fee Schedule Impact

Survey, December 1990), it appears that our faculty physicians, together with other Manhattan based physicians, will suffer the largest reductions of any group in the nation in payments for management and evaluation services under the new Medicare system. In contrast to the intent of the OBRA '89 legislation and the resource based fee schedule, our updated analysis (which uses the most recent information available, including the revised geographic adjustment factor for Manhattan included in the draft February 1991 PPRC "Chapter H: Geographic Adjustment Factors and Fee Schedule Payment Areas") indicates that reimbursement for management and evaluation services under the new system will be reduced by 20 to 25% for physicians practicing at our three affiliated hospitals.

While to date we have focused our impact analysis on management and evaluation services provided by Manhattan based physicians, it is anticipated that reductions in payments for all other services will far exceed those predicted for management and evaluation services in Manhattan. The combined effect will be crippling to Manhattan based medical schools, hospitals and their physicians. It will seriously undermine the ability of our faculty physicians to cover the costs of practice, and will jeopardize institutional efforts to retain and recruit the best physicians available to care for our medically underserved patients. It will also hurt our ability to fulfill our mission to achieve excellence in providing state of the art diagnostic and treatment services, to educate medical leaders of the future and to pioneer research breakthroughs in the diagnosis and treatment of diseases.

We believe that such a disastrous outcome for all Manhattan based physicians, especially for those teaching physicians serving large Medicare and indigent populations, who are making major contributions to medical education and research, is inconsistent with the intent of legislators, HCFA and the Physician Payment Review Commission (PPRC). We are convinced that the inadequate information used for calculating reimbursements for Manhattan-based physicians under the new system accounts, in part, for this unexpected and unintended effect. This can be corrected partially by establishing a special payment area designation for Manhattan that more accurately reflects the local costs of practice, including employee wages, office rent and malpractice insurance.

We are concerned that precedents set by Medicare, based on inaccurate data, may be followed by commercial insurers as well.

In summary, we urge the PPRC and HCFA to restudy this issue and to create a special payment area designation for Manhattan. We would be pleased to provide any additional data or assistance we can in this regard.

Sincerely,

HERBERT PARDES, M.D.
Vice President for Health Sciences
and Dean of the Faculty of Medicine

College of Physicians & Surgeons of Columbia University

OFFICE OF THE
VICE PRESIDENT FOR HEALTH SCIENCES
AND DEAN OF THE FACULTY OF MEDICINE

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November 3, 1990

Health Care Financing Administration
Department of Health & Human Services
Attention: BPD-699-NC, P.O. Box 26676
Baltimore, MD 21207

To Whom it May Concern:

I am writing on behalf of the College of Physicians and Surgeons of Columbia University to submit comments on the September 4, 1990 Federal Register preliminary Medicare Model Fee Schedule for physicians' services and related policy issues. The Columbia medical school has roughly 3000 full-time and part-time faculty physicians who practice medicine at eight affiliated hospitals in the New York City metropolitan region, upstate New York and Northern New Jersey. Both the medical school and its faculty are vitally concerned about this policy and its impact upon the practice of medicine.

While we are supportive of efforts to establish a more logical and equitable system of Medicare reimbursement for physician services, we are concerned that a number of the features of the proposed model fee schedule depart significantly from the principles set forth in the original legislation. With so many uncertainties remaining, we find it difficult to evaluate accurately the potential impact of the proposed fee schedule. Based upon the information now available, however, we have major concerns.

Preliminary Impact Analysis: Our preliminary analysis indicates that Medicare reimbursement for virtually all physician services provided in New York City would be reduced drastically under the proposed model fee schedule. In particular the model fee schedule would have an adverse impact on reimbursement for most all management and evaluation services in New York City, which is contrary to the intent of OBRA '89 and the resource based fee schedule. The attached table shows the variance between the estimated payment from the preliminary model fee schedule and the current Medicare prevailing rate for management and evaluation services in Manhattan. Reductions range from 9% to 68%, with an unweighted overall reduction in excess of 30%. Projected reductions in payments for other physician services in New York are well above that level. Thus the impact of the proposed model fee schedule would be devastating financially to the entire New York medical community.

Geographic Adjustment Factors: As presently constructed, we believe the methodology for calculating reimbursements may be seriously flawed and therefore, likely to produce unintended results. This could include withdrawal of many physicians from the Medicare program because of inability to cover the costs associated with providing care to the elderly.

We have questions about the $1 conversion factor which was computed using 1987 Part B Medicare Annual Data aged for 1988. While we understand that this factor is likely to change, its level obviously will be a major determinant of the adequacy of the overall level of reimbursement for physician services in the new Medicare system. In addition, we believe that the method of calculating geographic practice cost indices for employee wages, office rents and malpractice insurance in New York have major flaws as outlined below.

Employee Wages: Because the data used in developing the index are not current, they do not reflect the dramatic increase in wages for health care support personnel which have resulted from recent shortages of staffing in these areas. Such shortages have been particularly acute in New York in recent years. If the outdated census data from 1980 is not updated, it will be impossible for physicians caring for a large percentage of Medicare patients to sustain practices in areas with labor shortages.

Office Rents: In constructing the office rental portion of the index, apartment rent was used as a proxy for physician office rent. Such a proxy is totally invalid for New York because widespread rent control artificially depresses residential, but not commercial rents. We understand that for the New York Metropolitan Standard Area (MSA), because the value was recognized as implausibly low, data was substituted from Bergen and Passaic Counties in New Jersey. The resulting index substantially understates the true cost of renting office space in New York. Moreover, there are wide variations in office rental costs within the New York MSA. Office rental costs are far greater in Manhattan than in any other borough. Using a single geographic adjustment factor for the entire New York MSA will preclude Manhattan based physicians from coming anywhere close to recovering their costs for office space. We urge HCFA to incorporate local verifiable data into this office rental cost index to insure the integrity of the methodology.

Malpractice Costs: The malpractice cost adjustor for Manhattan is unrealistically low. In our experience, malpractice premiums in Manhattan range from 3 to 6 times higher than the national average, yet the adjustor for Manhattan incorporated in the model fee schedule is only 1.865.

Based on the above, we believe that Manhattan should receive a special payment area designation based upon extreme high variation of costs within the New York MSA region, and that the methods used to calculate the practice costs indices for all cost components should be revised substantially.

Coding of Management and Evaluation Services & Modifiers: With regard to coding revisions for evaluation and management services and incorporation of time into visit coding, we believe it is essential that the special role of teaching physicians be taken into account. Such physicians could be penalized by a coding system based on time as well as content, unless the levels of codes reflect the additional activities performed by teaching physicians. Time could be incorporated into office visit codes, secondary to content descriptors, but should not be a major factor in determining payment for hospital visits or consultations. We strongly support the recommendation of the Association of American Medical Schools that HCFA establish the reliability and accuracy of the revised codes in the teaching setting before they are implemented.

Global Surgical Fees and Post-Operative Visits: We urge HCFA to establish payment differentials based upon patient characteristics that affect the resources required for treatment. Physicians practicing at tertiary hospitals or serving inner city populations can be expected to attract a disproportionate share of complex cases and to have patients with higher than average incidence of co-morbidities and complications related to socio-economic status. Thus global surgical fees should be higher for physicians practicing in these settings. Similarly, highly trained specialists who receive the most complicated referrals would receive inadequate compensation under a system which proposes to pay all physicians an average fee. The Prospective Payments System for hospitals recognizes that hospitals serving special populations should receive higher compensation. Because physicians are even more likely than hospitals to have a non-random distribution of patients, they should be afforded similar treatment.

HCFA's proposal that all post-operative visits be covered under the global surgical fee for 90 days is also likely to cause distortions and is a much longer period than the current reimbursement standard in New York. Because some procedures require much more post-operative care than others, we believe the post-operative visit period should vary by procedure.

We appreciate the opportunity to comment and want to re-emphasize our serious concerns about many aspects of the proposed new Medicare payment system for physicians services. We urge HCFA, in particular, to consider carefully the impact of these changes on teaching physicians and academic medical centers in light of their special missions. We also urge you to work closely with specialty societies and the American Association of Medical Colleges to insure that the new system is equitable, easy to administer and does not result in unintended consequences.

Sincerely,

Kathleen O'Donnell
Associate Dean and
Deputy Vice President for
Medical Center Affairs

CORNELL UNIVERSITY MEDICAL COLLEGE
1300 YORK AVENUE • NEW YORK, NEW YORK 10021

THE STEPHEN AND SUZANNE WEISS DEAN
CORNELL UNIVERSITY MEDICAL COLLEGE

July 1, 1991

The Hon. Fortney Pete Stark
Chairman, Subcommittee on Health
c/o Robert J. Leonard
Chief Counsel and Staff Director
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Stark:

Cornell University Medical College appreciates the opportunity to comment on the proposed rules for physician Medicare fees published on the June 5, 1991. The revised relative value units multiplied by the geographic cost factors and the new, lower conversion factor predict a devastating reduction in Medicare revenue for physicians of all specialties practicing in Manhattan. The reduction is greater than the reduction estimated using the fees published in September, 1990 and it applies to both surgical procedures and primary care office visits. Attached is a letter we sent in February to the Physician Payment Review Commission which describes the impact of lower Medicare reimbursement on the Medical College and its faculty. If the new fees are fully implemented, we now expect a further decrease in overall revenue.

For Manhattan physicians, the two causes of the reduction in fees which are unreasonable are 1) the assumptions HCFA made to lower the conversion factor and 2) the incorrect data used to estimate geographic costs. We agree with the American Medical Association's analysis of the conversion factor and with their statement that a sixteen percent reduction at this time betrays the intention of the Medicare payment reform. In addition, although Manhattan is a separate payment area in the proposed regulations, the geographic cost factors are based upon regional data. Manhattan's higher actual costs are not reflected in the geographic cost factors and HCFA does not intend to update them until 1993 at the earliest.

We support your committee's efforts to seek technical correction to HCFA's proposed fees and to restore physician confidence in the payment reform process.

Very truly yours,

Robert Michels, MD
Dean

CORNELL UNIVERSITY MEDICAL COLLEGE
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THE STEPHEN AND SUZANNE WEISS DEAN
CORNELL UNIVERSITY MEDICAL COLLEGE

February 25, 1991

John Eisenberg, M.D.
Physician Payment Review Commission
Department of Medicine
100 Centrax
Hospital of the University of Pennsylvania
3400 Spruce Street
Philadelphia, PA 19104-4283

Lauren LeRoy
Deputy Executive Director
Physician Payment Review Commission
2120 L Street N.W. Suite 510
Washington, D.C. 20037

Dear Dr. Eisenberg and Ms. LeRoy:

The proposed 1992 Medicare fee schedule for physician services (Part B) will have a devastating impact on the faculty of every medical school located in Manhattan. The new levels of Medicare reimbursement will substantially reduce the funds available for medical faculty who teach medical students, train future physicians and perform clinical research. We must have a revision of the geographic adjustment factors in the Medicare fee schedule to recognize the cost of practicing medicine in Manhattan and the particular circumstances of the Manhattan medical schools.

Manhattan's prevailing prices and costs have not been appropriately recognized in preparing the Medicare fee schedule. This partly reflects the traditionally higher prevailing fees for Manhattan, but also incorrect assumptions about costs in the fee schedule methodology. The historic fee levels were based on the differential of practice costs in Manhattan. The incorrect cost assumptions are doubly erroneous if the Medicare fees are adopted by other insurers.

Medical Faculty Practice

Similar to other medical schools, Cornell University Medical College has a

large faculty of approximately four hundred full-time employed physicians who teach undergraduate medical students, train graduate medical staff and other health professionals, conduct clinical research investigations and engage in clinical practice activities. The clinical practice income collected from patients and insurance companies by the Medical College is used to support the infrastructure of the medical school, to pay for expenses associated with clinical practice as well as fund a portion of the faculty's compensation. In the last decade, as the costs of medical education have mounted and tuition and research funds have been limited, clinical practice income has had to carry an increasingly larger share of the total cost of operating the medical school and is now greater than 50% of total funding. In certain clinical departments, clinical practice income exceeds 80% of their funding.

Projected Reduction of Medicare Revenue

Medicare is an major payor of health care. Cornell faculty examine and treat a large number of Medicare patients, approximately 30% of our total services. More than 300,000 services were provided to Medicare beneficiaries by the full-time clinical faculty last year. Using the proposed Medicare fee schedule published in the September 4, 1990 Federal Register, we calculated the reduction in fees that will be effective January 1, 1992. We understand that the maximum reduction in any particular fee for the first year will be 15%, but even with this limit, the lost revenue to the medical school, including the loss of balance billing (assuming that patient mix and the volume of services remain the same) is estimated to be $11-12 million in the first year or an 11% drop in revenue. This is in addition to reductions already caused by the 1991 federal and state limits on charges. In subsequent years, the fees will decrease even further. These disastrous estimates will be made worse by the likely scenario that other health insurers will adopt the Medicare fee schedule as a template for reimbursement.

Manhattan Medicare Fees

Manhattan medical schools appear to be the ones anticipating the greatest decline in medical service revenue. The astonishing drop in Medicare fees for Manhattan will occur because both surgical and "cognitive" fees decrease substantially from the current prevailing levels. It was the intent of the resource based methodology to make more equitable the historic differences in reimbursement between surgical procedures and management or evaluation services. Medicare surgical and procedure fees at Cornell are expected to decrease an average of 42% in 1992 from the 1990 Medicare charges over the full implementation period. Management and evaluation services also will decrease an average of 37%.

In a survey recently completed by the Association for American Medical Colleges (AAMC), the Manhattan medical schools as a group will experience the largest collective decline in Medicare fees for a locality. The survey compared 1988 Medicare prevailing fees for internal medicine management and evaluation services with the new fee schedule. Fees in Manhattan will drop an average of 14.9%, will increase in Brooklyn by 17.7% and will increase in the Bronx by 29.9%. Weighted by the procedure volume performed in 1988 in the Manhattan medical schools, the average decrease in revenue for internal medicine management and evaluation services alone will range from 15.4% to 21.1% compounding the substantial reductions in procedure and surgical fees. Medical schools in Brooklyn and the Bronx expect increases in this category of medical services of 19% and 43% respectively which will help offset the reductions in surgical fees.

Geographic Adjustment Factors

The fee schedule methodology outlined in the September 4, 1990 Federal Register does include geographic adjustment factors for each locality and Manhattan is listed as a separate locality, indicating that it should be possible to calculate a fee schedule reflecting the costs of practice in Manhattan. However, Medicare has set the geographic practice cost indices for physician work, overhead and malpractice for Manhattan, Brooklyn and Queens at the same level. This is incorrect. For example, the proposed fee for an intermediate office visit with an established patient (CPT 90060) is $37.30 for Manhattan and Brooklyn and $37.14 for the Bronx and Suffolk. Cornell's 1990 average Medicare charge for this physician service was $59.06 representing a 37% decrease.

The geographic adjustment factor for practice costs includes an index for employee wages and rent. As has been pointed out by the Medical Society of the State of New York, the employee wage index was based on out of date information and does not correctly reflect the dramatic increases in wages for health care support personnel in Manhattan. The rent index also is incorrect. A proxy of commercial rents from nearby New Jersey was used in the calculations which is distinctly different from actual Manhattan rents. The rents for physicians offices in Manhattan are different from residential rents and from general commercial office rents. At the present time, physician offices in the community served by the Cornell faculty are being leased at more than $40 per sq. ft.

Special Analysis for Manhattan Requested

Cornell would like to see a special analysis of the assumptions used to calculate the Medicare fee schedule for Manhattan and a mechanism established to correctly recognize local costs and to minimize the impact of

these revised fees. We have been able to review a draft Chapter H of the upcoming Physician Payment Review Commission report. The draft contains the recommendation that current carrier localities be replaced with statewide payment areas with up to five payment areas defined for a state corresponding to MSA population categories. As outlined in the draft, that revised recommendation and associated geographic adjustment factor may help the fee levels over the previous levels published, but it will not provide for reimbursement differences between the boroughs of New York City, and, therefore, we do not anticipate that the Chapter H methodology significantly alters the projected decreases in revenue.

Impact of Medicare Revenue Decrease on Medical Education

A drop in Medicare revenue of of the magnitude described in this letter means that the activities of the clinical faculty at our medical school will be severely altered. The number of clinical faculty will have to be cut back reducing the number of hours of educational time available to the detriment of the overall educational program. Recruitment and retention of excellent clinical faculty to train future physicians will be handicapped. Reduced opportunities will be available to perform clinical research, and it will be difficult to pioneer new clinical treatment programs which would benefit Medicare patients.

As you can see, the new Medicare fees have an impact in the medical school setting which goes beyond the immediate transaction between a patient, a physician and Medicare. Cornell has strived to be one of the leading medical schools in the state and in the nation. Funding for our excellent faculty is extremely important, and we want the regulators in Washington to be aware of the connection between income from Medicare patients and medical education.

Very truly yours,

G. Tom Shires, M.D.
Dean

cc. Medical Society of the State of New York
Association of American Medical Colleges

Statement of the Honorable Marilyn Lloyd

Subcommittee on Health

Committee on Ways and Means

June 27, 1991

Mr. Chairman, I commend the Subcommittee on Health for their efforts to explore the new Medicare payment reform provisions of OBRA 1989, published in the Federal Register on June 5, by the Health Care Financing Administration. As you know, the proposal represents the most significant change in payment for physicians' services since the inception of Medicare. The changes are not only extensive and complex but will govern Medicare physician payment policies in major new ways.

Like many of you, I too have received a large volume of mail from specialty physicians in my district expressing disappointment and resentment to the proposal. Under the 1989 legislation directing the switch to a national uniform reimbursement schedule, Congress stipulated that the change be "budget-neutral" or that 1992 spending after payment reforms be the same as if there had been no change. However, HCFA projects that specialists such as internists, surgeons, radiologists, anesthesiologists, pathologists, ophthalmologists, and a host of others will see a decline in payments for their services by 25% to 30%. It has been suggested to me that the Health Care Financing Administration has failed to meet expected goals and is moving in a direction that will make it difficult to enlist physicians in future reform.

Of equal concern is the impact of the rules on Medicare patients. Its been suggested to me that the number of physicians accepting assignment could fall from today's levels - creating an even greater health care problem for the community. I support the Physician Payment Review commission, and as a strong proponent of the Medicare program, I encourage serious consideration be given to these arguments. It would be devastating for Medicare beneficiaries to see the number of Medicare participating physicians decline. The physicians of the Third Congressional District of Tennessee have made a good faith effort to be responsive to their Medicare patients. These physicians believe that their industry should be afforded responsive consideration. It is essential that a fee schedule be crafted that reflects the investment of their profession as well as the interest of Medicare beneficiaries.

STATEMENT FROM THE
MEDICAL SOCIETY OF THE STATE OF NEW YORK

The following comments represent MSSNY's concerns about the HCFA Medicare Fee Schedule Proposed Regulations published on June 5.

The published regulations are vague in a number of areas which make interpretation and estimation of the impact on New York physicians difficult. Specifically, it is unclear how historical data was aged to estimate the conversion factor and to carry out the simulations published with the regulations. MSSNY has not been able to duplicate these HCFA simulations.

The fee schedule appears to be complex and also vague in a variety of clinical areas, i.e. the regulations make clear that the published RVU's are a combination of Phase II and Phase III values, yet for any given procedure, it is unclear how the RVU's were calculated.

There also appears to be ambiguities about what the Department's recommendation will be with respect to aspects of the fee schedule critical to New York's interest. Will the current GPCI's be retained or will a new set based on PPRC's recommendations be substituted? If a new methodology of practice cost adjusters is to be implemented, how will New York be treated under the new system?

After the initial news releases, many of our physicians have expressed a lot of concern and dissatisfaction. They are upset with the fact that HCFA reduced payments in order to react to an expected surge in volume. This pre-judgment of physicians' responses invoked an immediate negative reaction from our physician constituents.

Our New York doctors are particularly concerned about the 25 percent limitation on reimbursement for geographic variations in physician practice costs. This provision substantially reduces payments to physicians in urban area of our state, and since it the responsibility of Congress, we ask that this calculation be revisited and a more appropriate practice cost differential be made to reflect actual costs.

For a program with implications and changes as drastic as those proposed by the HCFA regs to be of value to Medicare patients and physicians, it is imperative that these new regulations be understood by all concerned.

It is our belief that Congress should consider postponing the implementation of the regulations in order to clarify the points of confusion we have mentioned and the others that will be identified during the comment period.

Listed below is a simulation for RVU Value 27234. Our estimated 1992 payment is $2,853; estimated 1996 payment is $1,250. This represents a 58% reduction. This reduction appears typical for many of the procedural services for which we have conducted simulations.

EFFECT OF FEE SCHEDULE IMPLEMENTATION ON
RVU 27234 (Fractured Femur) IN MANHATTAN

FEE SCHEDULE AND PREVAILING DATA

	RVU	GPCI	RVU*GPCI
WORK	12.58	1.059	13.322
OVERHEAD	12.03	1.255	15.098
MALPRACTICE	1.98	1.647	3.261
SUM OF ABOVE:			31.681
COVERSION FACTOR:			26.873
ESTIMATED '91 PAYMENT:			851
MANHATTAN '91 PREVAILING:			2,991

CALCULATION OF PAYMENTS BY YEAR DURING TRANSITION

Note: must assume an update factor. This factor is initially recommended by HCFA, considered by PPRC, and finally set by the Congress. We will assume that the conversion factor is 8 percent in each year.

ASSUMED UPDATE FACTOR: 1.08

A. 1992 Estimated Payment

This figure calculated by taking the prevailing * 1.08 less .15 * estimated 1991 payment * 1.08. 2853.079

B. 1993 Estimated Payment

Calculated by adding .75*1992 estimated payment * 1.08 and .25 * 1991 fee schedule payment * 1.08 * 1.08. 2559.251

C. 1994 Estimated Payment

Calculated by adding .67*1993 estimated payment * 1.08 and .33 * 1991 fee schedule payment * 1.08 * 1.08 * 1.08. 2205.789

D. 1995 Estimated Payment

Calculated by adding .5*1993 estimated payment * 1.08 and .5 * 1991 fee schedule payment * 1.08 * 1.08 * 1.08 * 1.08. 1770.260

E. 1996 Estimated Payment

Calculated by multiplying the 1991 fee schedule payment by payment by 1.08 raised to the fifth power. 1250.929

SUMMARY OF PAYMENTS OVER TIME

	DOLLAR PAYMENT	PERCENT CHANGE FROM PREVIOUS YEAR
1991	$2,991.00	(Prevailing Charge)
1992	$2,853.08	-5%
1993	$2,559.25	-10%
1994	$2,205.79	-14%
1995	$1,770.26	-20%
1996	$1,250.93	-29%

Cumulative reduction between 1991 and 1996: -58%

Submitted by: Randall D. Bloomfield, M.D.
Chairman, Ad Hoc Committee on Physician Payment Reform
Medical Society of the State of New York

James J. Kropelin, M.D.
Chairman, Federal Legislation Committee
Medical Society of the State of New York

Charles N. Aswad, M.D.
President
Medical Society of the State of New York

STATEMENT OF THE NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS BEFORE THE HOUSE WAYS AND MEANS COMMITTEE, SUBCOMMITTEE ON HEALTH ON MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE-BASED RELATIVE VALUE SCALE

Introduction and Summary

The National Association of Portable X-ray Providers ("NAPXP") appreciates this opportunity to comment on the proposed application of the Medicare physicians' fee schedule to portable x-ray suppliers.

Portable x-rays are the services of a specially trained nonphysician portable x-ray technologist who drives a van containing an unassembled portable x-ray machine to a nursing home or patient's house, assembles the machine, takes the x-ray, disassembles the machine, and travels to the destination of another homebound patient. The portable x-ray consists of three components -- the transportation component, the technical component (the taking of the x-ray), and the physician's interpretation component (which is performed by an outside radiologist, not the nonphysician portable x-ray supplier).

Portable x-rays are among those diagnostic procedures incorporated in the broad definition of "physicians' services" established by the statutory mandate for the physicians' fee schedule in the Omnibus Budget Reconciliation Act of 1989 ("OBRA 89"). That definition, however, gives the Secretary of the Department of Health and Human Services ("HHS") discretion to exclude individual items or services from that definition. The Health Care Financing Administration's proposal for implementing the physicians' fee schedule (56 Fed. Reg. 25792, June 5, 1991) (hereinafter, "NPRM") proposes to include portable x-rays within the scope of the fee schedule, but does not prescribe a precise methodology for doing so. Specifically, the proposal for coverage of portable x-ray services in the physicians' fee schedule is that:

> all three components of the services of portable x-ray suppliers be paid under the fee schedule for physicians' services using the same CF as is applicable to all other services payable under that fee schedule. We are currently studying how to standardize the billing and RVUs assigned to the transportation component and specifically invite comments on this issue. If we do not standardize these payments in a final rule, the carriers will continue to establish RVUs for the transportation components based on the circumstances under which portable x-ray services are furnished in their service areas.

56 Fed. Reg. 806 (Jan. 5, 1991).

Thus, HCFA apparently proposes to calculate payments for the portable x-ray technical and professional components using the RVUs and conversion factor in the proposed physicians' fee schedule, but proposes no definite methodology for payment for the transportation component.

The NAPXP is now in the early stages of formulating its detailed comments on this proposal. At this stage, the Association's positions are two-fold: 1) that HHS should be directed to use its discretion to exclude portable x-ray suppliers from the fee schedule; and 2) alternatively, if the agency maintains its current position that these services should be included within the scope of the fee schedule, the reimbursement methodology should maintain payment levels that are "budget neutral" for this industry with respect to payment levels in 1991.

Both of these positions are addressed in the following statement. However, inasmuch as HCFA has proposed to incorporate

portable x-ray services within the fee schedule, we first address the Association's second position, i.e., that if portable x-rays are so treated, transportation component payments should preserve budget neutrality. Among the reasons for this position that will be explored below is the devastating financial impact that implementation of this proposal could have on the portable x-ray industry if budget neutrality is not maintained, an impact that the NAPXP has estimated for a sample of 23 individual companies. The methodology and results of this estimate are summarized below, and a complete tabulation of the results and explanation of the methodology are appended hereto.

The Methodology for Calculating Portable X-ray Payments under the Fee Schedule Should Preserve Budget Neutrality.

The reasons why HCFA should develop a methodology for reimbursing portable x-ray suppliers so as to preserve budget neutrality with respect to portable x-ray payments in 1991 are: 1) neither the method proposed by HCFA for achieving a "budget neutral" national conversion factor nor the Volume Performance Standard ("VPS") system is applicable to portable x-ray suppliers; and 2) failure to maintain budget neutral portable x-ray payments will likely destroy an industry which it is in Medicare's interest to sustain. Each of these arguments is discussed below.

1. Inapplicability of CF and VPS methodologies. The methodology used by HCFA to calculate a "budget neutral" national conversion factor ("CF") is not appropriate for portable x-rays and results in unwarranted punitive impact. HCFA's calculation incorporates a "behavioral offset" that assumes physicians whose fees for individual procedures will fall under the fee schedule will make up 50% of the loss by increases in volume. This concept is completely inapplicable to portable x-ray suppliers. Unlike physicians, portable x-ray suppliers have absolutely no control over the volume of their procedures. These procedures can only be provided pursuant to a physician's prescription. Moreover, unlike providers in some other non-physician specialties, portable x-ray suppliers are never consulted by physicians considering the advisability of performing the test in a particular case; thus, portable x-ray suppliers cannot even exert any indirect influence over the volume of their services.

The same point applies to the imposition of the VPS system on portable x-ray suppliers. The underlying rationale of the VPS is that the Medicare reimbursement system must incorporate incentives for physicians to restrain the growth in utilization of their services. Again, portable x-ray suppliers cannot be affected by such an incentive because they have no ability to control their volume. Indeed, the VPS may in fact create incentives for physicians to order fewer of those procedures, such as portable x-rays, from which they derive no financial gain, so as to make more "room" under the VPS for their own services.

Notwithstanding the inapplicability of these aspects of the physicians' fee schedule to portable x-ray suppliers, under HCFA's proposal, portable x-ray suppliers will be adversely affected by both of these facets of the fee schedule because both are incorporated in the calculation of the conversion factor. The "behavioral offset" affects the calculation of the initial conversion factor and the VPS affects the update for the conversion factor every year. Thus, portable x-ray suppliers will be unfairly and inappropriately penalized by the physicians' fee schedule. To offset this unfair and inappropriate penalty, the methodology for calculating portable x-ray payments should be developed so as to achieve an overall level of budget neutrality with respect to the level of portable x-ray payments in 1991.

2. Devastating impact on portable x-ray industry. The second reason why portable x-ray payments under the fee schedule should be developed in this fashion is that, if transportation

component payments were to remain at current levels while technical and professional component payments were calculated pursuant to the fee schedule as HCFA proposes, the level of portable x-ray payments would fall dramatically and result in the virtual eradication of this industry.

This conclusion is supported by a survey that the NAPXP has conducted among 23 companies represented by members of its Board of Directors and Legislative Committee. For these companies, the effect of the proposed physicians' fee schedule on portable x-ray payments using the above assumptions was calculated according to a methodology described in detail in Attachment 2. The results, aggregated in Attachment 1 and illustrated for several individual companies in Attachment 3, show that most of the 23 companies surveyed are operating today on margins well below 10%, and some are currently operating in the red. Under the proposed physicians' fee schedule, every single company would be operating in the red, and the majority would experience profit margin declines of well over 100%. The average 1992 profit margin under the fee schedule would be -28%, and the average decline in profit margin would be -697%.

It should be emphasized that portable x-ray suppliers, unlike most other Medicare-covered industries, could not obtain any relief from such drastic cuts by shifting to non-Medicare work because they have almost no non-Medicare work; since they serve only elderly, homebound patients, Medicare covers about 95% of their services. Medicare literally controls the destiny of this industry.

This devastating result is completely unsupported in the Congressional mandate for the fee schedule and is entirely contrary to the Medicare program's overall interest in the cost-effective provision of medical services to the nation's elderly. Nowhere in OBRA'89 is there any mandate for HCFA's "behavioral offset," for payment cuts for physicians' services as a whole or cuts for any particular industry, certainly not for the portable x-ray industry. Indeed, in the same statute, portable x-ray suppliers were exempted from a payment cut of approximately 4% that was applied to other radiology services on the grounds that they were overpriced; thus, Congress demonstrated its view that portable x-rays are not overpriced procedures, and consequently, there is no basis for imposing payment cuts on portable x-ray suppliers through the physicians' fee schedule.

Moreover, it would be counterproductive to permit fee schedule payment levels that would have the effect of virtually destroying this industry because it is the most cost-effective possible way for Medicare to deliver x-rays to patients in nursing homes. When a portable x-ray shows a negative result for the suspected diagnosis, the cost of more expensive medical treatment procedures is eliminated. Even when a portable x-ray is positive, where the diagnosis is pneumonia, tuberculosis, or other pulmonary disease or a simple fracture, treatment can be provided in the nursing home without removing the patient to the much more costly setting of a hospital. Where portable x-rays are unavailable, the patient must be transported in an ambulance to a hospital for the x-ray, an alternative that costs 3-4 times as much as the portable x-ray. (See Attachment 4, data on ambulance versus portable x-ray costs in several localities.) Furthermore, if the hospital x-ray is positive, the patient is most likely to be treated in the hospital, again, at a much greater cost than the Medicare program would bear if the patient were able to be treated in the nursing home.

Because of the cost-effectiveness of the portable x-ray service, it is in the interest of the Medicare program to encourage the continued existence of the portable x-ray industry so that there is enough capacity to meet the demand for portable x-rays by nursing home and homebound patients. That demand will grow exponentially in the next decade because the bulk of

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portable x-ray patients are the oldest and sickest of Medicare patients -- those in the 75-84 and the 85-and-over age groups, both of which are forecasted to grow at a much greater rate than the general Medicare beneficiary population (those 65 and over). Specifically, figures provided by the American Health Care Association ("AHCA"), based on recent Census data, indicate that, while the population of those 65 and over is expected to grow by 38% from 25.7 million in 1980 to 34.9 million in the year 2000, Americans aged 75 to 84 will grow by 58% in that 20-year period from 7.7 million to 12.2 million, and those 85 and older will grow by 102% from 2.2 million in 1980 to 5.1 million in the year 2000.

Existing data indicates that the capacity in the portable x-ray industry is already too small to meet the needs of nursing home and homebound patients for portable x-rays. A portable x-ray technologist x-rays an estimated average of 6.7 patients in a day and about 1560 in a year. Currently, there are about 220 active portable x-ray suppliers in the United States,[1/] employing an average number of six technologists each. Thus, the total annual capacity of the industry in 1990 is 2,059,200 nursing home/homebound patients x-rayed. The latest data available from the AHCA for the total United States nursing home resident population indicates that in 1985, the nursing home population totalled 1,491,400. The NAPXP estimates that the average nursing home resident needs a conservatively estimated annual figure of approximately three portable x-rays per year. Using these figures, the total estimated need for portable x-ray services is 4,474,200 x-rays, as compared to a portable x-ray industry capacity of only 2,059,200. Thus, the capacity of the industry currently fulfills only 46% of the need for the service; the rest is not being met or is being met through the much more costly alternative of the hospital.

If the proposed physicians' fee schedule were implemented without the budget neutral method urged by the NAPXP, eventually less or none of the total need for portable x-rays would be met by portable x-ray suppliers because the devastating impact described above would force portable x-ray suppliers to eliminate some and eventually all of their services, starting with the most costly rural routes and after-hours runs. Where a portable x-ray is not available, one of two things happens: either the patient is taken to a hospital in an ambulance instead, costing Medicare more; or the patient goes untreated, becoming sicker or dying. Neither of these results is in the interest of the Medicare program or its patients.

The Portable X-ray Status Quo
Should Continue at this Time.

The NAPXP asserts that portable x-ray services should not be reimbursed under the fee schedule and that portable x-ray reimbursement should remain at status quo for the following reasons.

1. Inadequate knowledge and study. HCFA apparently recognized that portable x-rays are a different service, functionally and in terms of input costs, from radiologists' services. This recognition is the foundation of the separate portable x-ray fee schedule that exists today and is reflected in the following language in Section 5262 of the Medicare Carriers Manual:

1/ There are more portable x-ray Medicare provider numbers than there are active portable x-ray suppliers because some of these Medicare provider numbers are inactive.

> For payments under the fee schedules, it has been determined that the technical component services furnished by portable x-ray suppliers are generally different from the technical component services furnished by others.2/

Beyond this statement, however, the agency has virtually no detailed knowledge of the portable x-ray industry upon which to base the incorporation of portable x-rays into the physicians' fee schedule.

The physicians' fee schedule itself is the product of enormous evaluation and study by a variety of expert groups: first, the Congressional policymakers who devised the general concept of an RBRVS-based fee schedule and subsequently reviewed reports on its development; second, the Harvard University team led by Dr. William Hsaio who conducted a multi-phased study of physicians' procedures and their resource inputs in order to identify and quantify those inputs; third, the PPRC that has many times reviewed and commented on the policy decisions of Congress and the work of Dr. Hsaio and his team; and finally, HCFA analysts and policymakers, who have also extensively evaluated the policy and payment implications of the RBRVS-based physicians' fee schedule.

As HCFA noted in the Preamble to the model fee schedule (55 Fed. Reg. 36178 (September 4, 1990)), this study and evaluation process "has been underway for a number of years" beginning with Congressional mandates in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, has reflected "considerable effort" by all parties involved, and has produced no less than three reports to Congress. Id. Thus, the physicians' fee schedule reflects extremely detailed consideration from experts representing varied perspectives on all aspects of physicians' services, their resource inputs, the incentives and disincentives created by Medicare's reasonable charge payment methodology for such services, and the practical and policy implications of moving from the reasonable charge methodology to the RBRVS fee schedule.

No such consideration has occurred with respect to the portable x-ray industry and the issue of whether or how to integrate portable x-rays into the physicians' fee schedule. At this point, there has been no adequate analysis of the portable x-ray industry, its cost structures and its resource inputs, notwithstanding the study now being completed by the HHS Office of Inspector General ("OIG") pursuant to the Congressional mandate in Section 6134 of OBRA'89. Although that study has made an attempt to analyze portable x-ray costs, the data received were inadequate to permit very reliable conclusions even about the limited subjects studied. This result is due in part to a relatively modest response rate3/. Principally, however, it stems from the fact that the study instrument itself, a

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2/ The reason why this difference exists is that geriatric patients -- the sole clientele of portable x-ray suppliers -- present problems for the practitioner that other patients do not. This difference was recently recognized by the Physician Payment Review Commission ("PPRC"), which noted on p.7 of its June 25 statement before this Committee: "Considerably more work is involved in providing certain services to elderly or disabled patients than to patients in the general population."

3/ The OIG study team has informed NAPXP representatives that they received 46 responses to about 100 questionnaires sent to portable x-ray suppliers; however, the OIG team has also stated that the response rate for the organized industry, NAPXP members, was much higher--80%.

questionnaire concerning portable x-ray costs, was not designed in accordance with the cost accounting methods used by portable x-ray suppliers -- despite extensive efforts by portable x-ray suppliers to explain these problems to the OIG.

Moreover, even if the data obtained in this OIG effort could be considered a reliable picture of the costs of portable x-ray suppliers, the study still will not be able to answer the question that is critical to the issue of how to incorporate portable x-rays into the physicians' fee schedule: precisely how, in terms of costs and resource inputs, do portable x-rays differ from radiologists' services? Unfortunately, the mandate for the study did not direct that radiologists' costs of furnishing services be considered along with portable x-ray costs, thus making it impossible for the study to yield the comparative evaluation that would be necessary to answer this question.

In short, beyond the basic understanding that portable x-rays constitute a separate service from radiologists' services, HCFA is simply not armed with the detailed data and understanding that should be a prerequisite to establishing a method for incorporating portable x-rays into the physicians' fee schedule. Without such knowledge, it is premature, imprudent and unfair to propose such action. The inequity is compounded by the fact that HCFA's June 5 NPRM makes no specific proposal at all as to how portable x-ray transportation payments are to be determined under the fee schedule, thus potentially depriving the industry of a meaningful opportunity to comment.

While the portable x-ray industry is small and no doubt insignificant in the overall scheme of the fee schedule, that fact does not justify hasty action that would sweep portable x-rays into the physicians' fee schedule without due deliberation, treating portable x-ray reimbursement as an afterthought. Inasmuch as Medicare pays for about 95 percent of portable x-rays, such action would hardly be an afterthought to portable x-ray suppliers or the elderly patients who depend on their services.

2. Unworkability of physicians' fee schedule methodology for portable x-rays. A critical reason why it simply does not make sense to incorporate portable x-rays into the physicians' fee schedule at this time is that the concepts and categories upon which the RBRVS itself is based do not apply or do not work in the portable x-ray setting. Each of these key concepts and categories is discussed below.

a. RVUs generally. Overall, RVUs designed for radiologists' services may very well not reflect the relative value differences between portable x-rays. An assumption underlying any RVUs for radiologists' office or hospital x-rays is that the nature of patients is constant from one procedure to another, and therefore differences in the values of procedures can be based solely on the resource inputs of the physician. In the portable x-ray setting, precisely the opposite is true. The principal circumstance that differentiates one particular portable x-ray procedure from another is not what body part (i.e., what procedure code) is being addressed, but rather the condition of the patient being x-rayed at the particular day and time in question.

It must be emphasized that a critical aspect of the portable x-ray business is that it serves an almost exclusively geriatric clientele. Patients receiving x-rays in a radiologist office can generally be expected to be the same in that they are ambulatory, of average hearing, of sufficient intelligence to comprehend and follow the instructions of the doctor or technician, cooperative in attitude, robust (i.e., not susceptible to orthopedic injury during the procedure), and not suffering from incontinence. In contrast, geriatric patients who are x-rayed in their nursing home beds vary widely among each other because of the numerous

conditions that may be found in elderly people and that have a significant impact on the duration and difficulty of the portable x-ray. For example, one patient may be senile, another lucid; one may be cooperative, another combative; one may be incontinent, another not; one may be suffering from extreme osteoporosis or other bone frailty that renders him/her susceptible to orthopedic injury, another not; one may be extremely hard of hearing or deaf, while another may be able to hear the technician extremely well; one may have palsy and move or shake during the procedure, requiring a repeat, while another may hold perfectly still; etc. Again, these differences between patients are by far the most significant contributing factors to differences between one particular portable x-ray procedure and another. Thus, the RVUs of the physicians' fee schedule, which assume a relatively constant patient, are entirely inapplicable to portable x-rays.

b. RVU components. Further, each of the components of the RVUs in the physicians' fee schedule that are to be applied to the technical component of portable x-rays, practice expense and malpractice expense, is extremely ill-suited to portable x-rays.

First, with regard to malpractice, there is no comparability between the RBRVS concept and the portable x-ray situation. Portable x-ray suppliers do not carry significant amounts of malpractice insurance. The principal reason for most portable x-ray suppliers to carry malpractice insurance is to cover the physician's interpretation in the case of global billers (portable x-ray suppliers who bill for their own services and also bill for the outside physician's interpretation). Portable x-ray suppliers more commonly carry general liability insurance. Insurance generally constitutes a more insignificant percentage of their overall costs (0-5 percent) than malpractice insurance does of physicians' costs (12 percent[4/]).

Second, portable x-ray practice expense includes very significant cost items (including film, vans and portable x-ray machines, and their maintenance and depreciation[5/]) that are not found in physicians' offices and were therefore not identified as input components of overhead for the physicians' fee schedule.[6/] Further, portable x-ray overhead constitutes a far

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4/ A chart in the NPRM (56 Fed. Reg. 25816) lists the proportions of gross revenues represented by physician work, malpractice and overhead across specialties. The total costs (represented by overhead and malpractice together) are 45.8 percent of gross revenues. Malpractice represents 5.6 percent of gross revenues and, therefore, 5.6% ÷ 45.8% = 12.2% of total costs.

5/ Another important cost incurred by portable x-ray suppliers that is not captured by the RBRVS overhead category relates to physician interpretations of portable x-rays. Because Medicare payments for the reading of x-rays such as chests and hips ($8.00-$14.00 per procedure, depending on locality) already do not compensate most radiologists adequately for the costs of performing the service, billing, collection, and bad debt, many radiologists demand that portable x-ray suppliers pay them a supplement to Medicare payments as a condition for providing portable x-ray interpretations. This situation will become more aggravated as radiologists' payments for interpreting portable x-rays fall dramatically under the fee schedule, particularly because portable x-ray procedures are the least remunerative radiology procedures for physicians to interpret.

6/ The NPRM identifies physician overhead components as employee wages, office rents, and equipment/supplies. See 56 Fed. Reg. 25816.

greater proportion of total revenues (75%-85%) than physicians' overhead does (40.2%, see 56 Fed. Reg. 25816).

Thus, none of the components of the total RVUs in the physicians' fee schedule make sense for portable x-rays, and the underlying methods by which these components were quantified for purposes of the physicians' fee schedule cannot be used for portable x-rays.

c. GPCIs. In terms of concept and methodology, the geographic practice cost indices ("GPCIs") of the physicians' fee schedule are also inapplicable to portable x-rays. Conceptually, the kinds of geographic variations that exist from one locality to another for physicians are unlike the kinds of geographic variations that can affect the portable x-ray service.

Because of the very fact that they are mobile services, portable x-rays are affected by actual physical geography and the urban/rural character of a locality in a way that physicians' services are not. For example, the cost of furnishing portable x-rays may be significantly greater in a highly rural area than in a suburban area because the significantly greater mileage that must be travelled increases the time required to complete each procedure and the costs of gas, depreciation and maintenance for portable x-ray vans. Similarly, the extremely dense traffic conditions that may exist in a highly urbanized setting may make portable x-rays more time-consuming to provide in that setting than in a suburban or less dense urban area. The quality of roads and difficulty of terrain also affect the time and difficulty involved in delivering the service and the cost of van maintenance and depreciation. Additionally, weather conditions significantly affect the costs of performing portable x-rays because harsh weather adds to total transportation time and significantly increases the costs of maintaining vans.

In the case of physicians' services, on the other hand, the differences from one locality to another are determined by differences in the costs of malpractice insurance -- a cost category that does not play the same role in the portable x-ray business -- and cost of living conditions. Geography and weather conditions play no role in differentiating localities for purposes of physicians' services.

Additionally, the GPCI methodology used in the RBRVS could not be applied to portable x-rays because of the very limited role of malpractice insurance in the portable x-ray industry and the very different allocation of costs among overhead and other items in the portable x-ray service as compared to physicians' services. Thus, the entire GPCI methodology would be inappropriate for portable x-rays.

In short, portable x-rays should not be included in the proposed physicians' fee schedule because the entire methodology for the new fee schedule was designed for physicians, not nonphysician technologists, and there has been no study of the portable x-ray industry or the relationship between portable x-rays and physicians' services upon which to base incorporation of portable x-rays into the fee schedule.

Conclusion

For the foregoing reasons, the NAPXP seeks the support of Congress in persuading HCFA either to use its discretion to exempt portable x-rays from the physicians' fee schedule -- at least until such time as there has been adequate study of the portable x-ray industry for this puprose -- or, at a minimum, to maintain budget neutrality with respect to portable x-ray payments in 1991 to avoid decimating this valuable industry.

ATTACHMENT 1

IMPACT OF THE PROPOSED PHYSICIANS' FEE SCHEDULE
ON PRE-TAX PORTABLE X-RAY PROFITABILITY*

Company Locality	1991 $ Profit	1991 % Profit	1992 $ Profit**	1992 % Profit	1991-1992 % Change (% Profit)
CA_1	15,543	?	(124,957)	(?)	(?)
CA_2	171,430	3.22%	(162,292)	(3.25%)	(200.9%)
CN_1	24,700	9.5%	(246,485)	(?)	(?)
CN_2	(733)	(.001%)	(40,399)	(?)	(?)
DE/PA	114,136	3.21%	(1,170,864)	(51.6%)	(1125.85%)
FL_1	50,000	9.16%	(32,200)	(6.44%)	(170.3%)
FL_2	132,340	9.1%	(137,380)	(9.44%)	(203.81%)
FL_3	(150,600)	(4.8%)	(1,051,632)	(30.71%)	(598.29%)
FL_4	21,670	2.8%	(354,580)	(?)	(?)
GA	32,710	4.2%	(8,953)	(1.17%)	(127.37%)
MA/NH/ME	1,765,000	18.39%	(4,950,000)	(171.58%)	(380.45%)
NE	(12,990)	(3.42%)	(53,655)	(14.14%)	(313.05%)
OH_1	267,300	9.27%	(67,738)	(2.35%)	(125.34%)
OH_2	2,040	0.18%	(107,802)	(9.75%)	(5384.41%)
OH_3	91,050	9.37%	(9,618)	(0.99%)	(110.56%)
OH_4	14,800	3.44%	(61,377)	(?)	(?)
OH_5	11,390	4.61%	(16,632)	(6.73%)	(246.02%)
OK_1	4,320	1.33%	(79,828)	(24.49%)	(1947.87%)
OK_2	(72,015)	(22.98%)	(130,777)	(41.74%)	(81.60%)
PA	336,198	8.01%	(1,162,674)	(43.11%)	(445.83%)
TX_1	(337,921)	(26.5%)	(499,075)	(44.80%)	(69.0%)
TX_2	23,250	(2.06%)	(50,704)	(4.5%)	(318.08%)
WA	35,262	?	(71,888)	(?)	(?)
Total Cos.: 23					

Simple average 1991 profit margin (total 1991 profit margin ÷ 17 companies): 2.52%
Simple average 1992 profit margin (total 1996 profit margin ÷ 17 companies): (27.27%)
Simple average profit margin decrease (total 1996 profit margin decreae ÷ 17 companies): (696.98%)

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* Assumes no transition rules, i.e., full impact of new fee schedule in 1992.

** Assumes 1992 global/technical payments computed per proposed physicians' fee schedule; 1992 transportation payments are the same as 1991 transportation payments; 1992 costs are the same as 1991 costs.

ATTACHMENT 2

METHODOLOGY USED IN ESTIMATING IMPACT OF PROPOSED PHYSICIANS' FEE SCHEDULE ON PORTABLE X-RAY PROFITABILITY

The methodology used by the National Association of Portable X-Ray Providers ("NAPXP") in assessing the impact of the proposed physicians' fee schedule on portable x-ray profitability was as follows.

Sample selection: The sample of portable x-ray companies for this calculation was chosen in effect randomly, by requesting members of the NAPXP Board of Directors and Legislative Committee to perform the calculation described below for each company they own and/or control. The resulting sample of 23 companies is varied in size and geographically, representing 14 states and 7 regions.

Assumptions: For purposes of this calculation, two assumptions were made: 1) that no transition rules would be in effect, i.e., that the full impact of the proposed physicians' fee schedule would be felt in 1992 (this assumption was simply made for purposes of simplification); 2) that technical component and professional component (if applicable) payments to portable x-ray suppliers would be calculated pursuant to the RVUs and conversion factor in the proposed physicians' fee schedule, but transportation component payments for portable x-ray suppliers would remain the same as they are in 1991; and 3) that each company's costs in 1992 would be the same as in 1991.

Calculation steps: The following steps were used in the calculation:

1. Identify those codes representing 75%-80% of technical and/or professional component procedures.

2. For each code, list the 1991 technical/global payment.

3. Calculate the estimated 1992 fee schedule payment by multiplying the geographically adjusted RVUs for the procedure times the $26.87 conversion factor.

4. Determine the decrease per procedure by subtracting (3) from (2).

5. Determine the total decrease for each code by multiplying the results of (4) by the 1991 annual frequency for the procedure.

6. Sum the results in (5) to obtain the total 1992 decrease for the identified procedures.

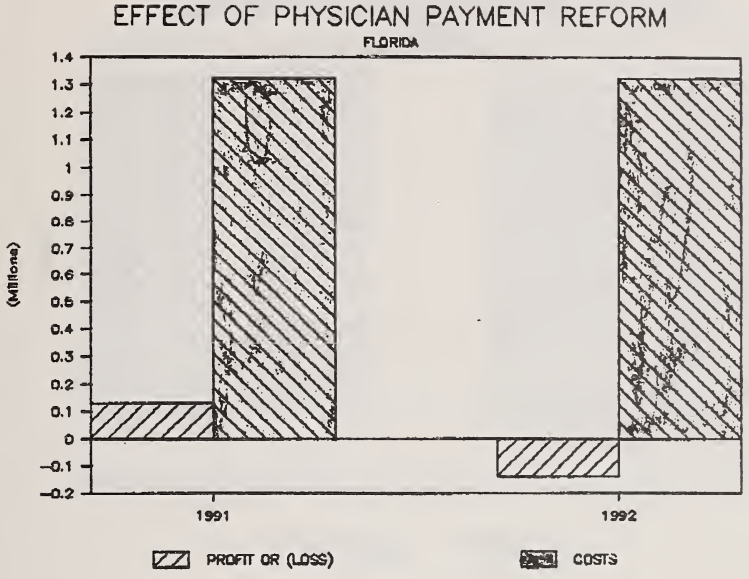
7. Estimate the company's total revenue decrease for 1992 by "grossing up" the total in (6) by dividing that number by the percentage of total technical/global procedures represented by the identified codes.

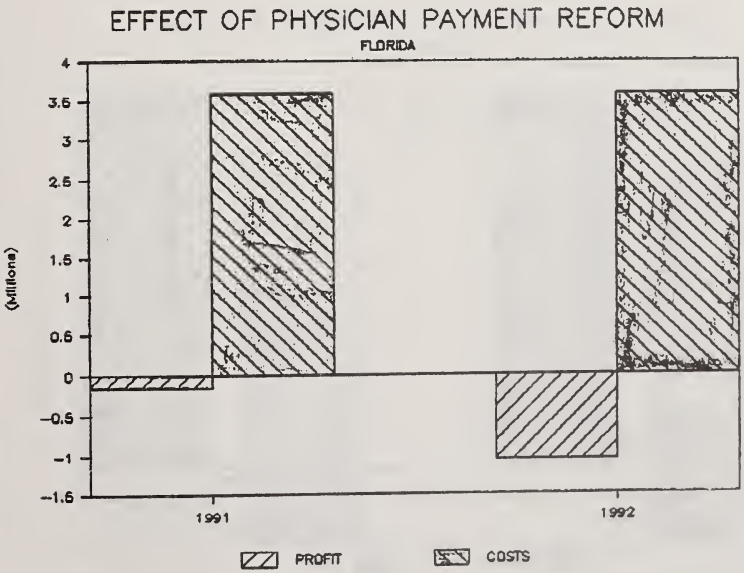
8. Subtract the total in (7) from 1991 gross revenues to obtain estimated 1992 gross revenues.

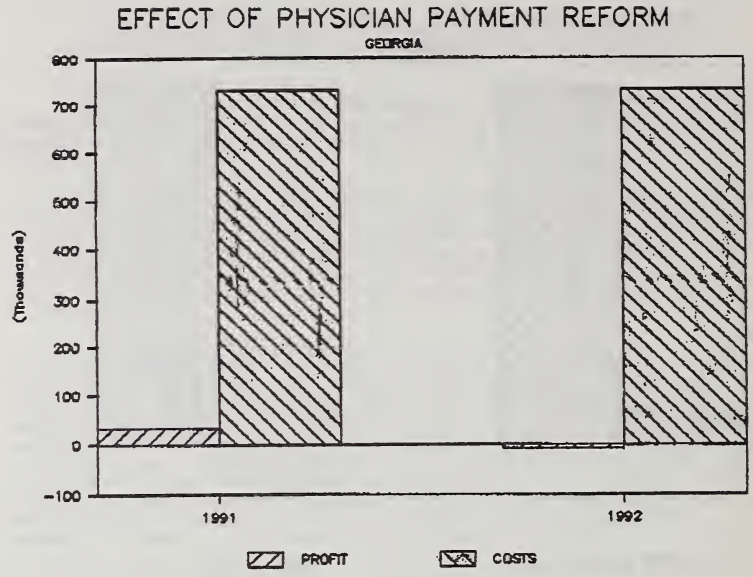
9. Using the 1992 estimated gross revenue figure in (8) and total costs from 1991, calculate dollar profit and % profit margin for 1992.

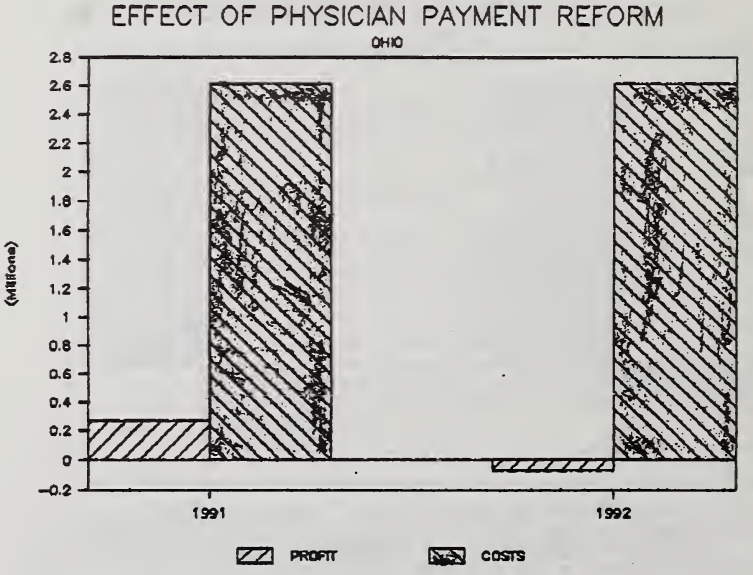
10. Calculate the decrease in profit margin from 1991 to 1992.

Aggregation procedure: Estimates of aggregate impacts of the proposed physicians' fee schedule on the entire industry were made by taking a simple average of the 1991 profit margins, a simple average of the 1992 profit margins, and a simple average of the profit margin decreases.

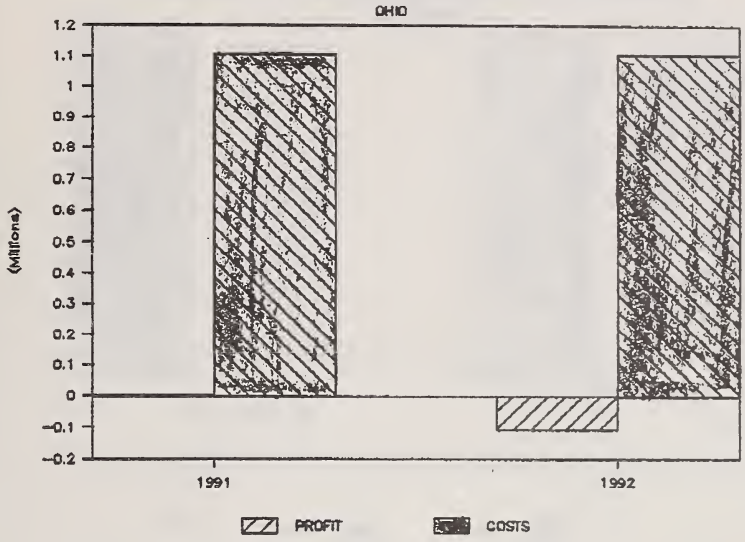

EFFECT OF PHYSICIAN PAYMENT REFORM
FLORIDA
(Millions)
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
−0.1
−0.2
1991
1992
PROFIT OR (LOSS)
COSTS


EFFECT OF PHYSICIAN PAYMENT REFORM
FLORIDA
(Millions)
4
3.5
3
2.5
2
1.5
1
0.5
0
−0.5
−1
−1.5
1991
1992
PROFIT
COSTS

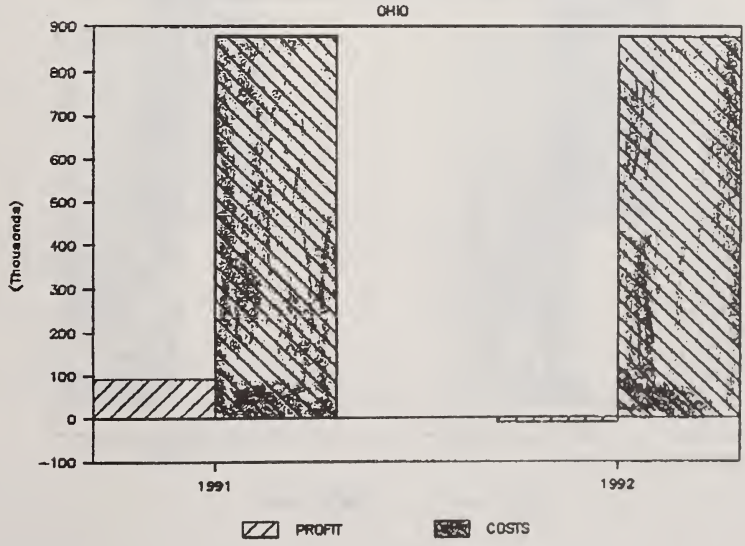

EFFECT OF PHYSICIAN PAYMENT REFORM
GEORGIA
(Thousands)
800
700
600
500
400
300
200
100
0
-100
1991
1992
PROFIT
COSTS


EFFECT OF PHYSICIAN PAYMENT REFORM
OHIO
(Millions)
2.8
2.6
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
-0.2
1991
1992
PROFIT
COSTS

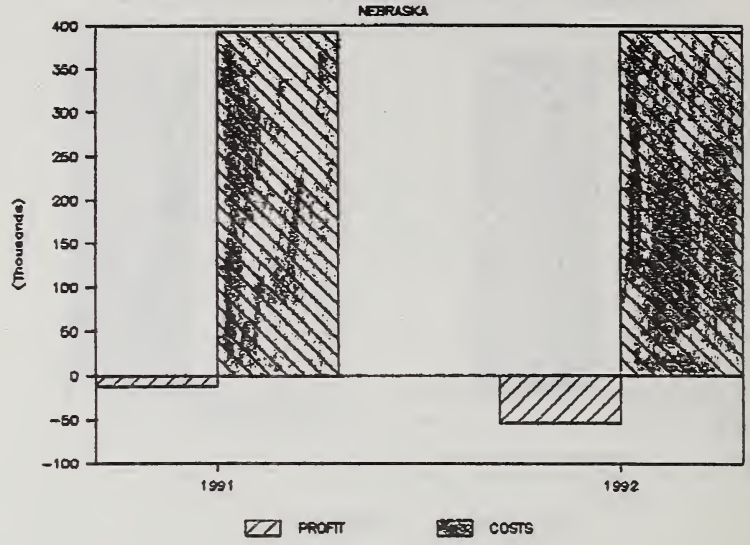
EFFECT OF PHYSICIAN PAYMENT REFORM



EFFECT OF PHYSICIAN PAYMENT REFORM



EFFECT OF PHYSICIAN PAYMENT REFORM



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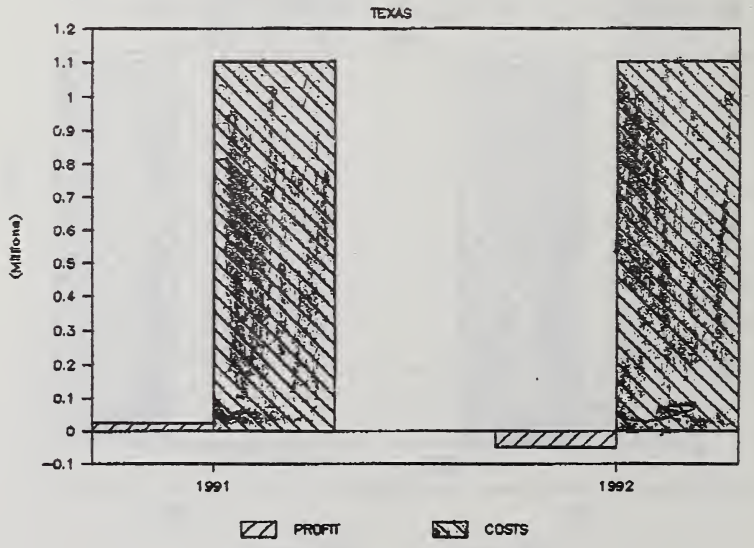
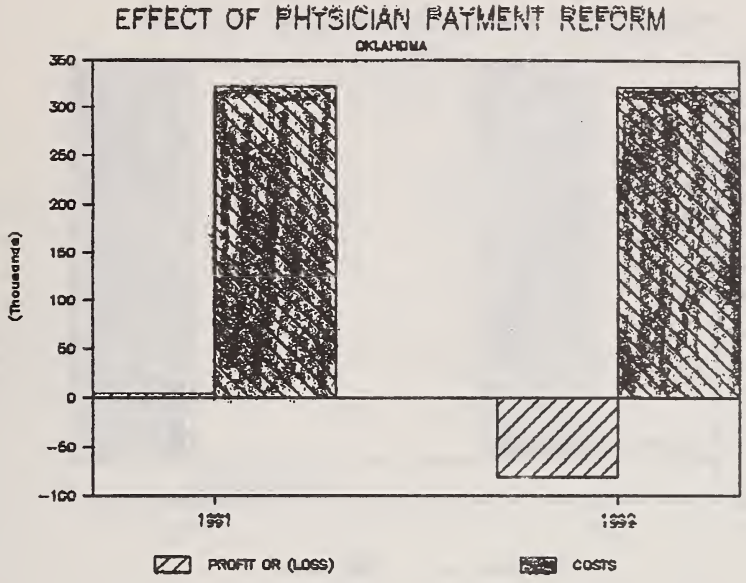
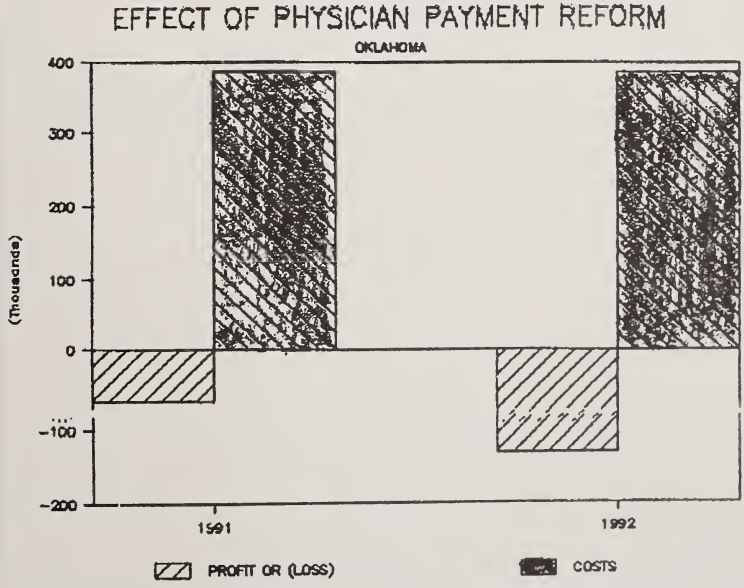
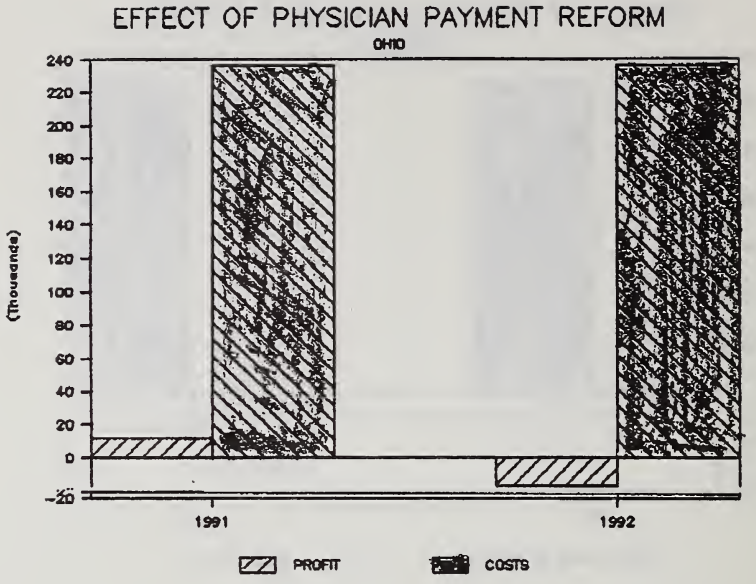



EFFECT OF PHYSICIAN PAYMENT REFORM
OKLAHOMA
350
300
250
200
150
100
50
0
-50
-100
(Thousands)
1991
1992
PROFIT OR (LOSS)
COSTS


EFFECT OF PHYSICIAN PAYMENT REFORM
OKLAHOMA
400
300
200
100
0
-100
-200
(Thousands)
1991
1992
PROFIT OR (LOSS)
COSTS

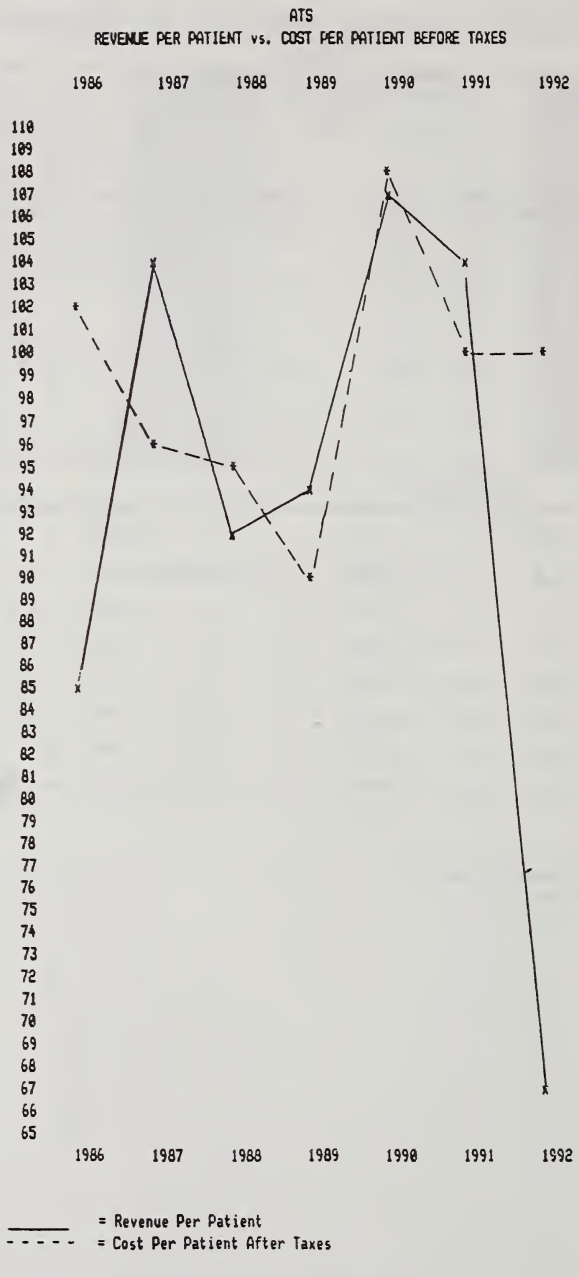

EFFECT OF PHYSICIAN PAYMENT REFORM
OHIO
(Thousands)
240
220
200
180
160
140
120
100
80
60
40
20
0
-20
1991
1992
PROFIT
COSTS

ATTACHMENT 4

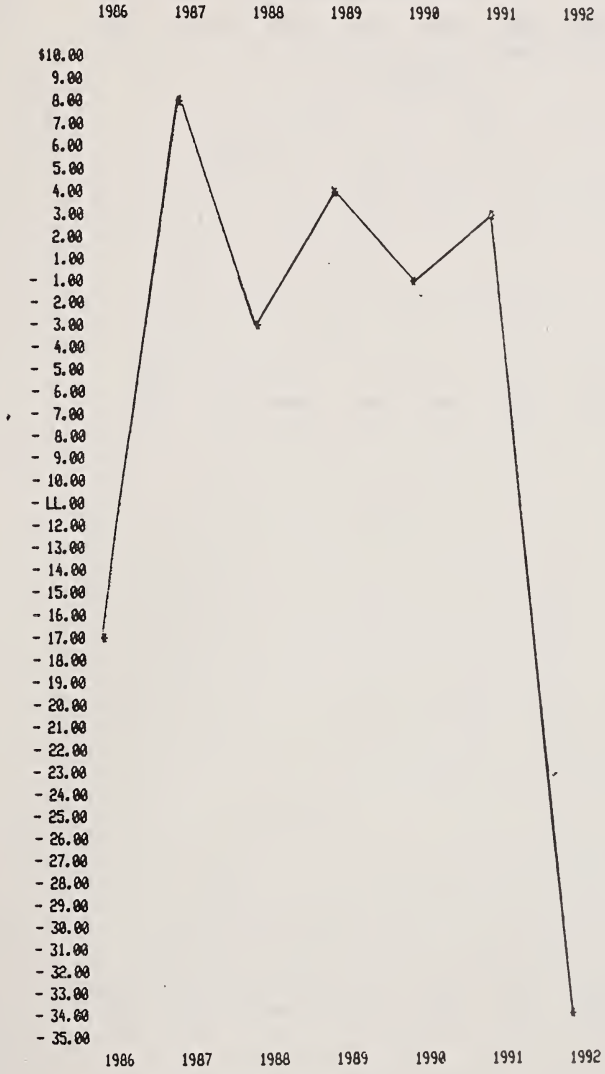
COMPARISON OF MEDICARE PORTABLE X-RAY
PAYMENTS & AMBULANCE/HOSPITAL X-RAY CHARGES
SELECTED LOCALITIES
1990

LOCALITY	ROUNDTRIP AMBULANCE[c]	EMERG. ROOM	RAD. DEPT. (X-RAY)	PHYS.FEES (RAD.AND/OR EMERG.RM.)	TOTAL HOSP.	PORTABLE X-RAY	PORT. X-RAY INTERP.	TOTAL PORT. X-RAY	AMB.-PORT. X-RAY
Tarzana, CA	302.00	135.00	86.50[a]	150.00	673.50	104.16[a],[g]	N/A	104.16	6.47
Plantation, FL	400.00	59.00	90.00[a]	50.00	599.00	90.25[a]	13.74	103.99	5.76
Tamarac, Davie, Plantation, Coral Springs, Hollywood, Margate, Sunrise, Hallandale, Cooper City and Lauder Hill, FL (2 hospitals)	306.00	59.50	120.00[b]	65.00	550.50	90.25[b]	13.74	103.99	5.29
	306.00	102.65	115.00[b]	115.00	638.65	90.25[b]	13.74	103.99	6.14
Clearwater, FL	270.00	96.50	80.15[a]	83.15	529.80	85.99[a]	13.14	99.13	5.34
St. Petersburg/ Tampa, FL	314.40	31.07[d]	98.72[a],[d]	N/A	444.19	98.09[a]	N/A	98.09	4.53
Miami, FL	352.00	156.67[d]	99.00[a],[d]	N/A	607.67	98.09[a]	N/A	98.09	6.19
Boston, MA	299.00	100.00	127.00[a]	13.64	539.64	163.64[a]	11.18	174.82	3.09
Quincy, MA	318.12	84.00	61.75[a]	13.74	477.61	163.64[a]	11.18	174.82	2.73
Lima, OH	318.00	75.00[d]	64.85[a],[d]	N/A	457.85	97.46[a]	N/A	97.46	4.70
Cleveland, OH	268.00	93.80[d]	68.28[a],[d]	N/A	430.08	97.01[a]	N/A	97.01	4.43
Central OH	226.00	54.95[d]	65.50[a],[d]	N/A	346.45	95.28[a]	N/A	95.28	3.64
Dayton, OH	238.00	32.18	55.63[a],[d]	N/A	325.81	98.04[a]	N/A	98.04	3.32
Newport, RI	176.58	69.00	13.09[a]	12.44	271.11	99.44[a],[g]	N/A	99.44	2.73

[a] Chest x-ray
[b] Hip x-ray
[c] Excludes oxygen fee; assumes 6-mi. round trip
[d] Average of area hospitals
[g] Global billing

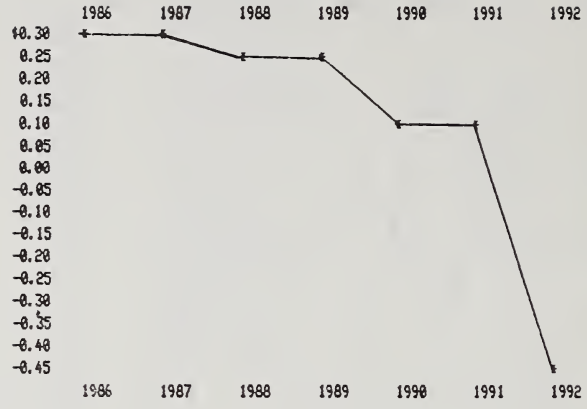

ATS
REVENUE PER PATIENT vs. COST PER PATIENT BEFORE TAXES
1986
1987
1988
1989
1990
1991
1992
110
109
108
107
106
105
104
103
102
101
100
99
98
97
96
95
94
93
92
91
90
89
88
87
86
85
84
83
82
81
80
79
78
77
76
75
74
73
72
71
70
69
68
67
66
65
= Revenue Per Patient
= Cost Per Patient After Taxes

ATS MEDICAL SERVICES
NET INCOME PER PATIENT
BEFORE TAXES

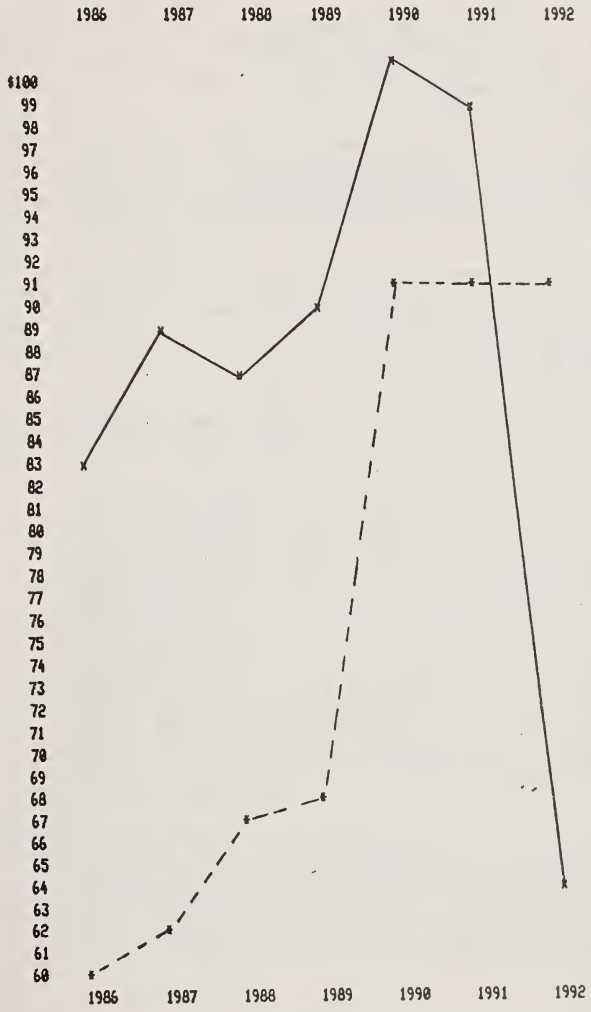


ATTACHMENT 3

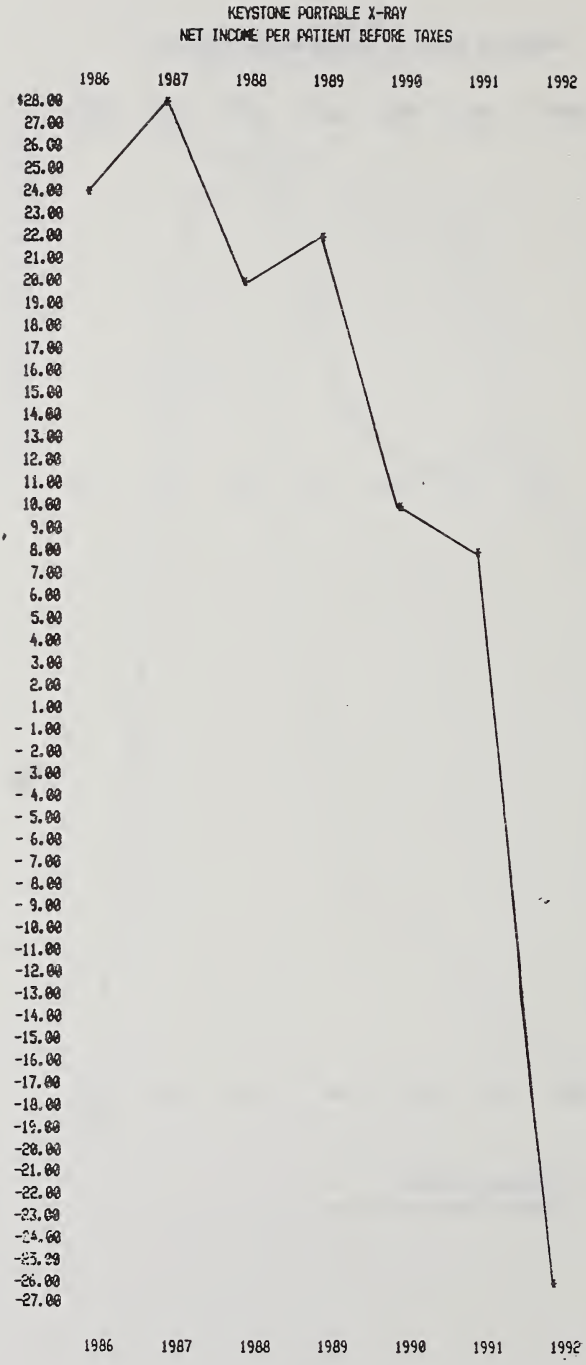
KEYSTONE PORTABLE X-RAY
PROFIT MARGIN BEFORE TAXES



KEYSTONE
REVENUE PER PATIENT vs. COST PER PATIENT BEFORE TAXES



_____ = Revenue Per Patient
- - - - - - = Cost Per Patient Before Taxes


KEYSTONE PORTABLE X-RAY
NET INCOME PER PATIENT BEFORE TAXES
1986
1987
1988
1989
1990
1991
1992
$28.00
27.00
26.00
25.00
24.00
23.00
22.00
21.00
20.00
19.00
18.00
17.00
16.00
15.00
14.00
13.00
12.00
11.00
10.00
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
- 1.00
- 2.00
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-11.00
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-15.00
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-17.00
-18.00
-19.00
-20.00
-21.00
-22.00
-23.00
-24.00
-25.00
-26.00
-27.00

Pathology Practice Association
1301 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 659-4593

STATEMENT SUBMITTED BY
PATHOLOGY PRACTICE ASSOCIATION
ON
HCFA'S PROPOSED MEDICARE FEE SCHEDULE

The Pathology Practice Association is a national association of pathologists from private practice, hospitals, independent laboratories, and academia. We appreciate the opportunity to comment on the proposed Medicare fee schedule, published in the June 5, 1991 Federal Register.

The proposed fee schedule is a disaster for many in the pathology profession. By the time cuts based on the relative value assigned to pathology services are combined with additional cuts based on budget neutrality as well as on expected changes in volume and intensity of service, the impact on pathologists is devastating.

Although the proposed rule estimates average cuts in pathology fees starting at 6% the first year and rising to 30% by 1996, pathologists in some localities report they would face reductions of up to 60%.

Historically, Medicaid reimbursement rates have been among the lowest in the country. In California, those Medicaid (MediCal) rates have not changed in ten years. Yet, reimbursement rates proposed in the Medicare fee schedule will be even lower than decade-old MediCal rates for some pathology services. For example, the proposed fee for code 88300 (Surg,Path,Gross) in the state of California is approximately $6.27 for the professional component. That is 32% below MediCal's $9.12 payment rate for the last ten years for the same service. For code 88304 (Surg,Path,Gross and Micro), MediCal has paid a rate of $30.40 for the last ten years. In contrast, the proposed fee schedule contemplates a payment of $18.03 for the professional component, 41% less than the MediCal rate. Only transition rules which phase in the cuts would soften the devastating impact.

We cannot believe Congress intended cuts of this magnitude. The RBRVS was intended to provide an equitable redistribution of payments for services among the various medical specialties. However, if one examines the effect of HCFA's proposed changes on pathologists' net income, based on HCFA's assumptions and on published income data, the shifts are dramatic and inequitable.

We believe that the inherent unreasonableness and inequitability of the RBRVS is illustrated by examining the effects of the payment changes on net income for pathologists and family physicians if all payors adopted the proposed Medicare payments. For example, 1988 data, attributed to the Medical Group Management Association, reported that the median net income for pathologists was $139,000. (Median net income is not the same as mean net income in HCFA tables, but for purposes of general analysis is used below.) Using HCFA's assumptions on overhead expenses, a pathologist making that median income would have to gross $199,000. If pathologists are to expect a 30% cut in payments when the RBRVS is fully implemented, then their median gross income should be expected to drop to approximately $139,000, out of which they must still pay some $60,000 in overhead. That would leave a median net income of only $79,000 for pathologists, a 43.1% reduction from the 1988 median net income figure.

Contrast that outcome with a family practitioner who, according to the same source in 1988, was making a net median income of $90,000. Because of high overhead expenses (as demonstrated in HCFA's tables), a family practitioner with that median net income would have to gross $205,000. According to the new fee schedule, family practioners can expect an ultimate 15% increase in their fees which would bring the gross income figure up to $236,000. Family practitioners' overhead, as before, would remain about $115,000 which, when deducted from the new median gross income level, leaves a net income of $121,000, a 33% increase in net income.

This analysis suggests a staggering shift in net income among medical specialties, leaving pathology at the bottom. We fear that if implemented, these radical changes will drive future physicians away from pathology and lead to shortages in pathology manpower to the detriment of medical colleagues and Medicare beneficiaries alike.

We join many of our colleagues in the medical profession in protesting the formula for determining the proposed fees. Our concerns are two-fold: the conversion factor and the relative value scale.

With respect to the conversion factor, we must oppose the 10.5% cut based on HCFA's judgments on anticipated changes in volume and intensity of services. Pathologists as a specialty should be excluded from this cut since they do not control the frequency of their services. Rather, volume and intensity of service is determined by how often surgeons and other physicians

operate or request a biopsy. That is beyond our control and thus is an inappropriate basis on which to penalize pathologists with additional cuts to already reduced fees.

Similarly, we join with many in the medical profession in protesting the across-the-board 6% cut to the conversion factor which HCFA has proposed to ensure budget neutrality. We encourage HCFA to work with Congress and the various interested parties to find an alternative to meet budget goals without the arbitrary effects of the current approach.

Although pathology values were restudied, the new fee schedule is more detrimental than the model schedule published last year. While Harvard researchers have demonstrated reproducibility of some of the results, they cannot verify that the results are accurate and reasonable. In particular, HCFA should reexamine the data on which it bases overhead expenses relating to practice and malpractice costs. These costs can run significantly higher than HCFA's tables would suggest.

In general, it is our view that the proposed Medicare fee system is inherently unreasonable for all medical services. For example, a pathologist would receive $5.64 in reimbursement from Medicare for examining a gross specimen, making a diagnosis, and dictating and reviewing a report. What service, provided by any profession, is reimbursed at such a low rate? Further, why should a plumber in Alexandria VA who makes a nighttime service call be able to charge $67.50 for a half hour when a pathologist in that community who makes a nighttime consultation during surgery (88331) will be paid approximately $46.79 or 30% less than a plumber?

We welcome HCFA's statement in the proposed rule that it will look at RVUs on an annual rather than five-year basis. Clearly, further work needs to be done on the RVUs for pathology services before those in the profession have confidence in its fairness.

We also take note of HCFA's proposal to use 15% of the 1991 adjusted historical charge as the basis for the technical component of pathology services pending receipt of more definitive data from Abt Associates. We view a 15% level of technical reimbursement as inadequate and urge HCFA to adopt a more flexible approach than a flat 15% for technical costs for all services.

It is not possible to determine, based solely on site of service, whether a pathologist is paying for technical costs. For example, while it is commonly assumed that charges from hospital-based pathologists are for the professional component only, some hospital-based as well as independent laboratory-based pathologists bear the technical cost for inpatient pathology. Some hospitals demand that pathologists pay for inpatient technical costs in order to maintain their hospital contract, even though these costs for Medicare patients are being reimbursed to the hospital through the DRG payment.

The technical costs of providing pathology services also vary significantly for different CPT codes, and case mix depends heavily on site of service. For that reason, technical costs cannot be expressed as a fixed percentage of total charge for the different CPT codes. Furthermore, case mix may be considerably different even within one type of service site. For example, the mix of services provided in a 50-bed rural hospital will be dramatically different than that at a tertiary care center with an emphasis in oncology. Thus, a fixed percentage factor for technical costs applied uniformly to all CPT codes would be unfair.

The technical component is a significant cost that must be recognized and reimbursed fairly. It must be distinguished from practice overhead as the latter is applied to both the professional and technical component. It should also be paid directly to the provider bearing the cost of the technical services.

We appreciate the opportunity to share our views on the proposed fee schedule and hope HCFA will make appropriate adjustments in implementing the final rule.

WRITTEN STATEMENT OF THE PUERTO RICO MEDICAL ASSOCIATION REGARDING MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RESOURCE BASED RELATIVE VALUE SCALE

SUBMITTED BY DR. JOSE ROMAN DE JESUS, PRESIDENT OF THE PUERTO RICAN MEDICAL ASSOCIATION ON BEHALF OF THE PUERTO RICAN MEDICAL ASSOCIATION TO THE HONORABLE FORTNEY PETE STARK (D. CALIFORNIA),CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, HEARING ON MEDICARE PAYMENTS TO PHYSICIANS UNDER THE RELATIVE VALUE SCALE.

I.Introduction

The purpose of this position paper is to express our concerns on the effects of the Physician Payment Reform on the practice of medicine in Puerto Rico, and to provide evidence that will help refine the present Geographic Adjustment Factor (GAF). It is important to make it clear that the Puerto Rico Medical Association understand the reasons for payment reform and support the efforts of the Administration and Congress to rationalize the pattern of Medicare payments to physicians and to slow the rate of increase in program costs.

Our concerns are basically geared to the effects of the reform on beneficiary access to health services in Puerto Rico. We believe that the adverse effects that the reform will have on Puerto Rico will compromise beneficiary access to health services.

After analyzing the technical aspects of the payment reform, the Puerto Rico Medical Association is concerned with the effects that the payment adjustments, through the Geographic Adjustment Factor (GAF), will have on the practice of medicine in Puerto Rico. The low values assigned through the Geographic Adjustment Factor (GAF) for Puerto Rico will reduce the aggregate payment level by more than 11 percent.

The Geographic Adjustment Factor for Puerto Rico is 17% lower than rural Arkansas which has the lowest GPCI in the U.S.. Although the legislation considers only 25% of the difference of the physician value of time, this does not change the relative position of the Puerto Rico GPCIs with respect to the rest of the areas. As a result, Puerto Rico is placed in an outlier position which results in unjustifiably lower levels of payments.

Given the outlier position of the GPCIs for Puerto Rico, we believe that there are assumptions in the Urban Institute study which may not pertain to our specific conditions. The first assumptions which may not carry through to the case of Puerto Rico are those related to the physician value of time. Another assumption is that equipment and supplies are bought in a national market and all areas face the same price.

II. Beneficiary Access

The overall reduction in the payment levels as a result of the GAF will greatly compromise beneficiary access to health care. Further, the increased differential in levels of payments between Puerto Rico and Mainland United States, will accelerate the present migratory patterns of Puerto Rican physicians to other states.

Presently, the support that the Medicare Program receives from physicians in Puerto Rico surpasses any other state. According to the Carrier in Puerto Rico 78% of all physicians have signed participation agreements with the Medicare Program. This figure

contrast radically with the 38% participation rate for the rest of the U.S. physicians.[1] Furthermore, physicians in Puerto Rico voluntarily accepted assigned payments for 98% of all Medicare claims.

It is expected that the overall reduction in the payment levels when the proposed GAF is applied to the payments in Puerto Rico will reduce our high rate of physicians currently accepting assignment. This is because many physicians in order to maintain their level of income will start balance billing within the acceptable range permitted by the Reform. This expected behavior will compromise beneficiary access to health care, especially, among low income individuals.

We believe that the increased differentials in the levels of payments between the mainland and Puerto Rico, as the result of the application of the GAF will further impinge negatively on beneficiary access by accelerating the present migratory patterns of Puerto Rican physicians to other states. In the last five years according to information provided by the three medical schools in Puerto Rico, 40% of the medical graduates leave for the mainland for their residency. Approximately, 70% of this group goes on to practice on the mainland and do not return.

Given the nature of health services in Puerto Rico, where the government is a direct provider, it is expected that if physicians start balance billing the beneficiaries a significant proportion of these will move to the public sector to receive their health care. This action will create further pressures for budgetary allocations which could also affect the access of the rest of the population receiving their health services from the government.

III. The Urban Institute Study

The Health Care Financing Administration commissioned the Urban Institute to carry a study in order to calculate an index by which the Medicare payment schedule would be adjusted in order to capture practice cost differences between geographic areas. The Urban Institute in trying to estimate the differences in physician value of time through geographic cost of living and amenities differentials, used an earnings index approach. In the absence of physician income data (for the reasons well justified) the authors used the income of other occupations as a proxy of physician nominal income. The main assumption of this approach is that the income differentials of an occupational group will be explained by the geographic differentials, across states, in cost of living and amenities.

This assumption implies that the market for this occupational group is constrained from the supply. If this is so, then, higher cost of living areas have to offer a premium over other areas to attract labor. In this case, the earnings differentials could be explained by cost of living differential after controlling other variables, as the authors stated. We believe that this behavioral assumption is sustainable in economies with a low unemployment rate. However, in the case of regional economies with a historical structural rate of unemployment fluctuating between 14 and 17 percent it would be difficult to expect that earnings will track the cost of living.

Evidence available tends to support this contention. Using the 1980 Census, we have analyzed the same data used by the Urban Institute in its calculations. The table below shows the distribution by sex and employment status of people living in Puerto Rico with 5 or more years of university or college education and 59 years of age or less. According to these results almost 14% of males in this population are either unemployed or out of the labor force. This last category represents all those who have stopped searching for work. For females in this last category (unemployed,or out of the labor force) the percent increases to 25.8%.

[1]Source: Physician Payment Review Commission, Annual Report to Congress 1989 page 361.

EMPLOYMENT STATUS BY SEX
FOR THE PUERTO RICAN POPULATION
WITH 17 OR MORE YEARS OF EDUCATION
ACCORDING TO THE 1980 U.S. CENSUS

	MALE	ROW FEMALE	TOTAL
EMPLOYED	1345	725	2070
	65%	35%	100%
	86.3%	74.1%	
UNEMPLOYED OR NOT SEARCHING	223	253	466
	48%	52%	100%
	13.7%	25.8%	
COLUMN TOTAL	1558	978	2536

It is unlikely that in this type of economy an earnings index of salaried personnel will track cost of living. However, the high cost of living in Puerto Rico has been historically recognized by the Federal Government. Federal employees in Puerto Rico have been receiving a cost of living allowance of 10% not subject to federal income taxes since 1978. Chapter 591 of the Federal Personnel Manual, which deals with Allowances and Differentials Payable in Non-Foreign Areas, explicitly recognizes that cost of living in Puerto Rico is higher than in mainland U.S.

IV. Evidence of a Higher Cost of Living In Puerto Rico than in Mainland U.S.

In addition to the explicit recognition from the Federal Government that Puerto Rico has a higher cost of living than mainland U.S., further evidence is provided in this section. Here evidence is provided on goods and services that compose 70% of the consumer basket in the calculations of the consumer price index (CPI). These items are housing, food, energy and transportation.

a. Housing

The GPCI itself presents evidence of our high cost of living, the rent component of the GPCI for Puerto Rico is over .90. Rents and housing value should correlate with the permanent income expectations of residents of a determined geographical area. In this sense the rent component of the GPCI provides a good approximation of physician income price relative.

In order to provide additional evidence, published information from a recognized Real Estate Company was gathered. Coldwell Banker publishes annually a guide for comparing home prices across North America. This Real Estate Company compares a single family dwelling of approximately 2,200 square feet with 4 bedrooms, 2 1/2 baths, family room and 2-car garage. The home and neighborhood are typical for a corporate middle-management transferee. In this guide the cost of this home in San Juan, Puerto Rico for the fourth quarter of 1990 was $237,833. This cost was higher than the costs of a similar residence in the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana,Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska,, Nevada, New Hampshire, New Mexico,North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington State, Wisconsin, and Wyoming.

b.Food

Food and beverage represent in most consumer baskets the group with the major relative importance in consumer expenditures. Because Puerto Rico resources are devoted toward the production of manufactured goods which are exported[2], most food and clothing consumed in Puerto Rico must be imported. A study conducted in 1989 for the Commonwealth Department of Social Services concluded the following:

[2]It may be noted that 85% of Puerto Rico's manufactured goods are exported to the U.S. mainland markets.

The weekly food costs of a consumer unit in Puerto Rico in 1989 amounted to $75.87, as compared to an average of $67.62 in the mainland U.S.

The difference between weekly food costs in Puerto Rico and the U.S. was 4.4% in 1984, this difference increased in 1989 to 12.2%. This implies that a consumer that paid $100 for food in the U.S. had to pay $112.20 in Puerto Rico.

Experts in Puerto Rico agree that the main culprit of higher food costs in Puerto Rico is maritime transportation.[3] A 1988 survey of the 25 of the largest food handling businesses in Puerto Rico showed that maritime transportation represented an average of 10% of their costs. For example, according to information from Trailer Maritime Transport Corp. (TMT) a 40,000 pound container of meat cost about $4094 to ship from the Port of Miami to San Juan including new fuel surcharges. This amounts to an additional 10 cents per pound.

The Federal Government in recognizing cost of living differences between Puerto Rico and mainland U.S., pays a 10% cost of living adjustment. It is important to note that the cost of living allowance includes the payment for cited differentials in food prices.

c.Energy

Energy prices is another component where cost of living differences can be documented. In the case of electricity rates we analyzed information from the Energy Information Administration. According to the consolidated statistics, in 1987 in the U.S. the average price per kilowatt hour in the U.S. was 5.01 cents with a standard deviation of 1.19 cents. In Puerto Rico the average price reported was 8.05 cents.[4] This means that electricity rates in Puerto Rico are more than two times the standard deviation of the average rates in mainland U.S.. In the same publication the other two non-contiguous states, Hawaii and Alaska reported an average price of 6.87 cents and 7.90 cents, respectively.

Gasoline prices are also higher in Puerto Rico than in mainland U.S.The next table shows prices for regular unleaded gasoline during the first week of April in selected cities in the U.S.[5]

City	Price/Gallon
Boston.MA	$1.25
Providence,RI	$1.21
Hartford,CN	$1.23
Chicago,IL	$1.15
Puerto Rico	$1.32

V. Why medical equipment is more expensive in Puerto Rico than in Mainland U.S.

The second assumption of the Urban Institute study considers medical supplies and equipment to be bought in a national market. The specific geographic circumstances of Puerto Rico, being an island with at least more than 1,000 miles away from the nearest mainland coast, suggest a certain degree of difficulty in justifying this assumption. Available evidence provides support to the fact that medical supplies and equipment cost substantially more in Puerto Rico than in mainland USA. Puerto Rico imports most of its consumer goods as well as durable goods.

Assuming that the main difference in the cost of medical equipment are the cost of transporting this equipment, the Puerto Rico Medical Association gathered information on freight costs of medical equipment from the Puerto Rican Maritime Authority as of April

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[3] The San Juan Star, Business Sunday, "Why do Puerto Ricans pay so much to eat? Shipping rates blamed for higher food prices" The San Juan Star, Sunday, September 2, 1990.

[4] Energy Information Administration, Typical Electrical Bills, U.S. Government Printing Office, Washington, D.C. 1988, page 296.

[5] Source: Telephone survey conducted to gasoline service stations in those cities.

1990. Information was gathered about two classifications of health related equipment and supplies. These are disposable hospital ware and durable medical equipment. Information on transportation costs was collected for cargo leaving the ports of Charleston, New Jersey, New Orleans and Jacksonville. The cost of transporting disposable hospital ware to Puerto Rico from the ports of Charleston, New Jersey and Jacksonville are:

$1.62 per cubic foot + $0.25 per 100 pounds (adjustment) + a terminal charge of $0.67 per 100 pounds + a fuel surcharge of 5% of the costs of transportation.

The cost of transporting disposable hospital ware from the port of New Orleans is the same except for the main item which is $1.78 per cubic foot.

The freight for medical equipment from Charleston and Jacksonville is the following:

$3.39 per cubic foot + a terminal charge of $0.95 per 100 pounds + a fuel surcharge of 5% of the costs of transportation.

The cost From New Orleans and New Jersey are $3.57 per cubic foot.

These freights represent equipment costs differences of at least 20% without including insurance costs. Theses freights evidence the contention of the Puerto Rico Medical Association that the assumption of equal equipment costs for all areas does not apply in this specific case.

VI. Final Remarks

It has been the intention of the Puerto Rican Medical Association to express concern in specific areas of the Urban Institute study, especially the applicability of the discussed assumptions. We are aware that the case of Puerto Rico deviates partially from the rest of the states. In acknowledging this fact our main purpose has been to provide you with additional information to explain why the computed GPCIs for Puerto Rico resulted in outlier in the very low end of the distribution.

In the specific case of Puerto Rico, the assumption of national markets for medical supplies and equipment cannot be applied. This assumption underestimates our true cost of these items.

The Puerto Medical Association has provided evidence on why Puerto Rico experiences a higher cost of living than mainland U.S..The evidence provided serves to confirm the federal cost of living allowance category of local retailing where it recognizes a higher cost for local goods and services. This evidence contradicts the findings of the Urban Institute Study and their justifications for a GAF of 0.81 for Puerto Rico. The evidence presented here supports the arguments of the Puerto Rico Medical Association that the present GAF does not reflect the true costs of practicing medicine in Puerto Rico.

The Puerto Rico Medical Association is truly concerned with the effects of the Medicare Fee Schedule on beneficiary access. It is important to stress that 98% of physicians in Puerto Rico accept the Medicare payment as total and do not balance bill beneficiaries. The application of the present GAF will compromise beneficiary access to health care, because in order to maintain their level of income, it is expected that physicians will start balance billing within the limits permitted by the Reform. This practice will increase the pressure for further budgetary allocations from the Federal Government.

The Puerto Rico Medical Association believes that given the inapplicability of the methodology with which the GAF was developed and the adverse effects of its application in Puerto Rico, that no geographic adjustment factor should be applied in this case. The Medicare Fee Schedule applied to Puerto Rico should reflect national average payments in order to mitigate its projected adverse effects.

We welcome this opportunity to express our concerns with the Medicare Fee Schedule and to provide additional information to identify feasible alternate solutions to approach them. Once more, thank you for the opportunity provided. We are confident that given the agenda agreed upon by the Administration and Congress to implement the Medicare payment reform, there is time to address these concerns.

STATEMENT OF THE RENAL PHYSICIANS ASSOCIATION

The Renal Physicians Association (RPA) is pleased to provide a statement to the Subcommittee Health, Committee on Ways and Means on Medicare payments to physicians under the resource-based relative value scale (RBRVS) especially in light of the Administration's recently proposed rule which translates the RBRVS into a Medicare Fee Schedule for physician's services.

RPA appreciates Chairman Stark's and the Subcommittee's commitment to ameliorate the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a Medicare Fee Schedule which is both fair and equitable. While RPA will provide comments to HCFA on several areas of concern, we will focus our comments here on the most problematic to all of organized medicine – the reductions to the conversion factor.

Reductions in the Dollar Conversion Factor:

If the proposed rule were implemented as written, drastic, unnecessary and unanticipated reductions in physician fees of over $12 billion would be realized by 1996, due to conversion factor reductions of 16 to 22 percent, despite Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting devise. It is because of these reductions to the dollar conversion factor, more than any other reason, that physician payments will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained to the letter of OBRA '89, and therefore call upon the Congress to correct for them through legislative action. But, Congress need also mandate HCFA in other areas to reverse all of the unnecessary reductions to the dollar conversion factor proposed by HCFA which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

Behavioral offset adjustment: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4.5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

RPA maintains that no behavioral offset assumption be employed by HCFA because we believe that the Volume Performance Standards will take care of any unanticipated increase in volume as they provided a mechanism for HCFA to recommend lesser updates if expenditures exceed the target. Regarding HCFA's arguments against having the VPS take care of all unanticipated volume increases, if problematic, Congress could simply recommend greater reductions in updates if merited, or change the default formula. Additionally, given the great uncertainty admitted by HCFA, the Congressional Budget Office (CBO), and the Physician Payment Review Commission (PPRC) as to physician responses to the new payment system, and the lack of substantial data on the subject (even the most relevant data employed by HCFA on this issue (Christensen) is severely limited – it is outdated (1976), only general practitioners and internists were studied, the data was gathered from a single state, etc.), Congress should legislate that HCFA be prohibited from using a behavioral offset assumption in its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

Transition rules adjustment: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made; but HCFA staff now say that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6.2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

Crosswalk to the new visit codes: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have

reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

Summary of HCFA's conversion factor reductions:

-10.5%	behavioral offset -- no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment -- $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone -- $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk -- no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF -- would translate into over $12 billion (plus savings due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS, despite Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. RPA urges Congress to enact legislation which would return physician payment reform to the budget neutral basis on which is was intended. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further unnecessarily reduce the conversion factor.

RPA is sensitive to the pay-as-you-go budget rules passed last year, and would prefer alternatives that would not trigger it. However, we cannot stand by and watch physician payment reform be brutalized by HCFA and by technical drafting errors. RPA would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

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